NJDOH EBOLA INVESTIGATION WORKSHEET

MR #: _____ **CDRSS #: _____**

Submit with all laboratory test results via encrypted email to CDSEVD.SME@doh.nj.gov or fax to 609-826-4874.
Questions? Call 609-826-5964.

Demographics

Patient Last Name	First Name	DOB:	Phone number
		____ / ____ / ____	
Address		**City**	**Municipality**

Ethnicity
- ◯ Hispanic
- ◯ Non-Hispanic
- ◯ Unknown

Race
☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown

Occupation	Industry / work setting

Physician and Facility Information

Was patient hospitalized because of this illness?

◯ Yes ◯ No ◯ Unk

Hospital: _____

Admit: ___ / ____/ ___ Discharge: ___ / ____/ ___

Did the patient die because of this illness?

◯ Yes ◯ No ◯ Unk

If yes, date of death: _____ / _____ / _____

Treating physician

Name:
Address:
Phone: Fax:
Email:

Hospital Laboratory Contact Information

Name:
Address:
Phone: Fax:
Email:

Clinical Status

Sign/Symptom	Response	Onset	Additional required information
Abdominal pain	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Anorexia	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Chest pain	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Conjunctivitis	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Diarrhea	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Fatigue	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Fever (≥100.4°F)	◯ Yes ◯ No ◯ Unk	___ /___ /_____	Temperature: _____°F
Headache	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Myalgia	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Shortness of breath	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Unexplained hemorrhage (bleeding or bruising)	◯ Yes ◯ No ◯ Unk	___ /___ /_____	Describe:
Vomiting	◯ Yes ◯ No ◯ Unk	___ /___ /_____	
Weakness	◯ Yes ◯ No ◯ Unk	___ /___ /_____	

Other symptoms/underlying medical conditions, *describe*:

Alternate Diagnosis:

Is the person **vaccinated** for Ebola? If yes, type and # of vaccines and when (if they don't know, have the person estimate the year, and request their immunization records)

◯ Yes ◯ No ◯ Unk

Vaccination: Date: ___ /___ /_____ Vaccination: Date: ___ /___ /_____

RISK FACTORS (Ask all of these questions for the 21 days preceding illness onset or diagnosis)
List of areas with active Ebola virus transmission can be found at: https://www.cdc.gov/vhf/ebola/outbreaks/index-2018.html

Was the patient in an area with active Ebola virus transmission? ◯ Yes ◯ No ◯ Unk	Location: Date(s):
Did patient have close contact with a sick person(s) who was recently in an area with active Ebola virus transmission? ◯ Yes ◯ No ◯ Unk	Describe contact: Date(s):
Did the patient attend a funeral in an area with active Ebola virus transmission? ◯ Yes ◯ No ◯ Unk	Location: Date(s):
Did the patient have contact with semen from a man who recovered from Ebola virus disease (through oral, vaginal or anal sex)? ◯ Yes ◯ No ◯ Unk	Specify body fluids: Date(s):
Did the patient have direct contact with blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, semen) of a person who was sick with or who died from Ebola virus disease? ◯ Yes ◯ No ◯ Unk	Describe contact: Date(s):
Did the patient have direct contact with fruit bats or nonhuman primates (e.g., apes, monkeys) in an area with active Ebola virus transmission? ◯ Yes ◯ No ◯ Unk	Describe contact: Date(s):
Did the patient have direct contact with objects contaminated with body fluids from a person sick with Ebola virus disease or have direct contact with the body of a person who died from Ebola virus disease? ◯ Yes ◯ No ◯ Unk	Describe contact: Date(s):
Did the patient work in a laboratory where Ebola specimens were handled or in a clinical laboratory in an area with active Ebola virus transmission? ◯ Yes ◯ No ◯ Unk	Describe work: Location: Date(s):
Was the patient a caregiver for an Ebola patient or healthcare worker in an area with active Ebola virus transmission? ◯ Yes ◯ No ◯ Unk	Describe contact: Location: Date(s):
Did the patient visit a health care facility or traditional healer in an Ebola disease outbreak area? ◯ Yes ◯ No ◯ Unk	Reason for visit: Location: Date(s):
Did the patient attend a funeral or burial in an Ebola disease outbreak area? ◯ Yes ◯ No ◯ Unk	Describe participation: Location: Date(s):
Did the patient perform burial work in an Ebola disease outbreak area? ◯ Yes ◯ No ◯ Unk	Describe work: Location: Date(s):

Describe other exposures and what (if any) PPE was used:

DIAGNOSTIC TESTING

Name of Test	Performed?	Date of specimen collection	Result Positive, Equiv., Abnormal, Negative, Normal
Malaria	◯ Yes ◯ No ◯ Pending	____ / ____ / ____	
Influenza	◯ Yes ◯ No ◯ Pending	____ / ____ / ____	
Blood culture	◯ Yes ◯ No ◯ Pending	____ / ____ / ____	
CBC	◯ Yes ◯ No ◯ Pending	____ / ____ / ____	
Chemistry	◯ Yes ◯ No ◯ Pending	____ / ____ / ____	
PT/INR	◯ Yes ◯ No ◯ Pending	____ / ____ / ____	
Urine analysis	◯ Yes ◯ No ◯ Pending	____ / ____ / ____	

Other testing, specify:

DETERMINE CONTACTS/ EXPOSURES:
Contact tracing should begin to determine household and other close contacts.

Name	*Full Address*	*Telephone #*	*Date of Birth*	*Relationship*
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
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			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	

Does patient live with any pets (e.g., dogs, cats, pigs)? ◯ Yes ◯ No ◯ Unk

Specify number and type of animal(s):

CASE NOTES