North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

HEMORRHAGIC FEVER VIRUS INFECTION
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 68

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
☐Yes, subjective ☐No
☐Yes, measured ☐Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):____/____/____
Fatigue or malaise or weakness ☐Y ☐N ☐U
Shock ☐Y ☐N ☐U
Was systolic BP <90mm Hg ☐Y ☐N ☐U
Shock was: ☐Septic ☐Hypovolemic
Hemorrhagic ☐Y ☐N ☐U
Altered mental status ☐Y ☐N ☐U
Patient displayed (select all that apply)
☐Confusion ☐Coma
☐Delirium ☐Anxiety/apprehension
☐Dementia
Muscle aches/pains (myalgias) ☐Y ☐N ☐U
Skin rash ☐Y ☐N ☐U
Onset date (mm/dd/yyyy) _____
Location:
☐All over the body (generalized)
☐Generalized, predominantly central/torso/back (centripetal)
☐Generalized, predominantly face/hands/feet (centrifugal)
☐Localized/focal
☐Palms and soles
Appearance (select all that apply)
☐Macular ☐Petechial
☐Papular ☐Unknown
☐Vesicular
Bruising (echymoses) ☐Y ☐N ☐U
Disseminated intravascular coagulation (DIC) ☐Y ☐N ☐U

Thrombocytopenia (platelets < 100,000/mm^3) ☐Y ☐N ☐U
Hemorrhagic symptoms/signs ☐Y ☐N ☐U
Specify (check all that apply):
☐Vaginal bleeding ☐Melena ☐Other
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
Specify: _____
Restrictions to movement or freedom of action? ☐Y ☐N
Check all that apply:
☐Work ☐Sexual behavior
☐Child care ☐Blood and body fluid
☐School ☐Other, specify
_____
Date control measures issued:____/____/____
Date control measures ended:____/____/____
Was patient compliant with control measures? ☐Y ☐N
Discharge/Final diagnosis: _____
Did patient have a travel history during the 21 days prior to onset? ☐Y ☐N ☐U
List travel dates and destinations:
From _____/_____/_____ to _____/_____/_____
_____

TREATMENT
Did the patient receive an antiviral for this illness? ☐Y ☐N ☐U
Antiviral name _____
Was antiviral prophylaxis given prior to illness onset? ☐Y ☐N ☐U
Did the patient require mechanical ventilation? ☐Y ☐N ☐U

ISOLATION/QUARANTINE/CONTROL MEASURES
Did local health director or designee implement additional control measures? ☐Y ☐N
If yes, specify: _____
_____
Were written isolation orders issued? ☐Y ☐N ☐U
If yes, where was the patient isolated? _____
_____
Date isolation started:____/____/____
Date isolation ended:____/____/____
Was the patient compliant with isolation? ☐Y ☐N ☐U
Were written quarantine orders issued? ☐Y ☐N
If yes, where was the patient quarantined?
_____
Date quarantine started:____/____/____
Date quarantine ended:____/____/____
Was the patient compliant with quarantine? ☐Y ☐N
Notes:

CLINICAL OUTCOMES
Survived? ☐Y ☐N ☐U
Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐U
Date of death (mm/dd/yyyy):_____/_____/_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (_____) _____ - _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy): ____/____/____

Number of days hospitalized at time of report: _____

TRAVEL/IMMIGRATION

The patient is:

- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ None of the above

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

List persons and contact information:

_____

_____

_____

Additional travel/residency information:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U

Is patient a student? ☐ Y ☐ N ☐ U

Type of school:

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U

Give details:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 21 days prior to onset of symptoms did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify: _____

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) _____
- ☐ Unknown

ANIMAL EXPOSURE

During the 21 days prior to onset of symptoms:

Did the patient have exposure to household pets or other animals (includes animal tissues, animal products, or animal excreta)**?** ☐ Y ☐ N ☐ U

Specify animal(s) _____

_____

Did patient work with animal importation? ☐ Y ☐ N ☐ U

Did the patient work at or visit a zoo, zoological park, or aquarium? ☐ Y ☐ N ☐ U

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? ☐ Y ☐ N ☐ U

Provide the nature of contact, dates, location, and other specifics for any question answered yes.

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 21 days prior to onset of symptoms, did the patient have any health care exposures such as hospitalization, ER visit, outpatient clinic, long term or other institutional care? ☐ Y ☐ N ☐ U

Nature of exposure _____

Name of facility: _____

Location/address: _____

City: _____ State: _____

Zip code: _____

Telephone: (_____) _____ - _____

Other occupation, specify _____

Puncture or accidental stick with needle or other object known to be or possibly contaminated with blood? ☐ Y ☐ N ☐ U

Please provide details of puncture or stick: _____

_____

_____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

If yes, specify:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): _____/_____/_____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed?

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County _____

☐ Outside NC, but within US

City _____

State _____

County _____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes: