Ebola Viral Disease Person Under Investigation (PUI) Form State/Local ID: ______ CDC ID: ______

I. Patient Information

Date of form completed : MM / DD / YYYY   Date PUI identified: MM / DD / YYYY

Form Administrator

Name (Last, First): ______________________________ Affiliation: ____

City: _________________________ State: ________ Zip: __________County: ______________________________

Phone number: _________________________ Email address: ____

Patient Information

Patient Name (Last, First): ____________________________________ Sex: ☐ Male ☐ Female

Date of birth: MM / DD / YYYY   Age Group: ☐ Adult ☐ Pediatric (< 18 years)   Age: _________

Citizenship:_____________________ Country of Residence: ☐ U.S. ☐ Other (specify): ____________________

Number of household contacts: ________

Patient Hospitalization Is the patient currently admitted to a hospital? ☐ Yes ☐ No Date of admission: MM / DD / YY

Facility Name:___________________________________ City: ________________________ State: _________

Physician Name (Last, First): _______________________ Contact Information: ___________________________

Is the patient being treated under isolation precautions? ☐ Yes ☐ No   Date of isolation: MM / DD / YY

Was the patient transferred from a previous health care facility? ☐ Yes ☐ No

Facility Name:___________________________________ City: ________________________ State: _________

II. Medical History and Symptom Onset

Medical History:

Have you experienced any of the following symptoms?	If yes, date symptom began (___/___/____)
☐ Fatigue	
☐ Fever/Feverish Temp:_____	
☐ Headache	
☐ Stomach pain	
☐ Muscle pain	
☐ Diarrhea	
☐ Unexplained bruising/bleeding	
☐ Vomiting	
☐ Other:	

III. Epidemiologic Risk Factors

1. Have you had contact with a suspect/known case of Ebola in the 3 weeks before becoming ill?

   ☐ Yes ☐ No ☐ Unknown

   If yes, name: ____________________________

   State/Local ID: __________ CDC ID: ________

   If yes, please describe:

2. Did you traveled outside of the United States in the 3 weeks before becoming ill? ☐ Yes ☐ No

   Country (1) : ______________________________

   MM / DD / YYYY to MM / DD / YYYY

   Country (2) : ______________________________

   MM / DD / YYYY to MM / DD / YYYY

   Did you provide health care for any known/ suspect cases of Ebola? ☐ Yes ☐ No

   If yes, please describe:

IV. Laboratory Testing

Test 1

Originating Facility: ______________________ City: ______________ State: ________

Point of Contact: ______________________

Phone Number: ______________________ E-mail: ______________________

Where was testing performed? ☐ LRN: ______________________ ☐ CDC

Specimen ID: ______________________

Test Performed (PCR, BioFire Defense FilmArray): ______________ Test Date: MM / DD / YYYY

Result: ☐ Positive ☐ Negative ☐ Inconclusive Result Date: MM / DD / YYYY

Test 2

Originating Facility: ______________________ City: ______________ State: ________

Point of Contact: ______________________

Phone Number: ______________________ E-mail: ______________________

Where was testing performed? ☐ LRN: ______________________ ☐ CDC

Specimen ID: ______________________

Test Performed (PCR, BioFire Defense FilmArray): ______________ Test Date: MM / DD / YYYY

Result: ☐ Positive ☐ Negative ☐ Inconclusive Result Date: MM / DD / YYYY

Test 3

Originating Facility: ______________________ City: ______________ State: ________

Point of Contact: ______________________

Phone Number: ______________________ E-mail: ______________________

Where was testing performed? ☐ LRN: ______________________ ☐ CDC

Specimen ID: ______________________

Test Performed (PCR, BioFire Defense FilmArray): ______________ Test Date: MM / DD / YYYY

Result: ☐ Positive ☐ Negative ☐ Inconclusive Result Date: MM / DD / YYYY

Test 4

Originating Facility: ______________________ City: ______________ State: ________

Point of Contact: ______________________

Phone Number: ______________________ E-mail: ______________________

Where was testing performed? ☐ LRN: ______________________ ☐ CDC

Specimen ID: ______________________

Test Performed (PCR, BioFire Defense FilmArray): ______________ Test Date: MM / DD / YYYY

Result: ☐ Positive ☐ Negative ☐ Inconclusive Result Date: MM / DD / YYYY