

EBOLA CASE INVESTIGATION FORM – Sierra Leone

Date of Case Report: / /

Outbreak Case ID: **KAI0507234**

Patient is a followed contact: **Convert to CASE in VHF**

Complete at end of interview: suspect probable unk



Patient's Last Name: _____ **First Name:** _____

Age: _____ **Unit:** Years Months **Gender:** Male Female

Patient Status at Time of This Report: Alive Dead **If dead, Date of Death:** _____

Permanent Residence:

Head of Household: _____ **Village/Town:** _____

District: _____ **Chiefdom:** _____ **Mobile phone #:** _____

Patient's Occupation:

Healthcare worker (includes anyone involved with the patient: nurse, ambulance driver, hospital cleaner, etc.)

Position: _____ **Healthcare facility:** _____

Other; please specify occupation: _____

Location Where Patient Became Ill:

Village/Town: _____ **District:** _____ **Chiefdom:** _____

Date Patient First Became Sick: / /

Read each one aloud and mark an answer for every symptom occurred during this illness (not only right now):

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Vomiting/nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Difficulty breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Difficulty swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Conjunctivitis (red eyes)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Skin rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Intense fatigue/weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Hiccups	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Anorexia/loss of appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Unexplained bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	If yes, please specify: _____			
Muscle pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Other symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
Joint pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	If yes, please specify: _____			

At the time of this report, is the patient hospitalized or being admitted to the hospital? Yes No Unk

If yes, Date of Hospital Admission / /

Hospital Name: _____ **District:** _____

Is the patient now, or will he/she soon be, in an Ebola treatment unit? Yes No Unk

If yes, date of admission (or future admission to the ETU (isolation): / /

Was the patient hospitalized or visited a clinic previously for this illness (this includes any type of care: pharmacist, traditional healer, etc.)? Yes No Unk

If yes, Dates of Hospitalization: / /

Hospital Name: _____ **District:** _____



KAI0507234



KAI0507234



KAI0507234



KAI0507234



KAI0507234



KAI0507234

IN THE PAST ONE (1) MONTH PRIOR TO SYMPTOM ONSET:

Outbreak Case ID: **KAI0507234**



1. Did the patient have contact with a suspected or confirmed Ebola case in the one month before becoming ill?

Yes No Unk

If yes, please complete one line of information for each sick source case:

Name of Source Case	Relation to Patient	Date of Last Contact (DD, MM, YYYY)	Village/Town	District	Was the person dead or alive?
		... / ... / ...			<input type="checkbox"/> Alive <input type="checkbox"/> Dead Date of Death: ... / ... / ... (DD,MM,YYYY)
		... / ... / ...			<input type="checkbox"/> Alive <input type="checkbox"/> Dead Date of Death: ... / ... / ... (DD,MM,YYYY)

2. Did the patient attend a funeral in the one month before becoming ill? Yes No Unk

If yes, Name of deceased person	Relation to Patient	Date of Funeral (DD, MM, YYYY)	Village/Town	District	Did the patient participate? (carry or touch the body)?
		... / ... / ...			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Did the patient travel outside their hometown or village/town before becoming ill? Yes No Unk

If yes, Village: _____ Chiefdom: _____
 District: _____ Date(s): / / - / /

Case Report Form Completed by:

Name: _____ Phone: _____ E-mail: _____
 Position: _____ District: _____ Health Facility: _____
 Information provided by:
 Patient Proxy *If proxy, Name:* _____ *Relation to patient:* _____

Patient Outcome Information:

Please fill out this section at the time of patient recovery and discharge from the hospital OR patient death.

Date Outcome Information Completed: / /

Final Status of the Patient: Alive/Recovered Dead

If the patient has recovered and been discharged from the hospital:

Hospital discharged from: _____ District: _____

Date of discharge from the hospital: / /

If the patient is dead:

Date of Death: / /

Place of Death: Community Hospital District: _____

Date of Funeral/Burial: / /

Funeral conducted by: Family/community Outbreak burial team

Place of Funeral/Burial: Village: _____ Chiefdom: _____ District: _____

EBOLA Clinical Specimens and Laboratory Testing

Outbreak Case ID: **KAI0507234**



Sample 2

Date of Specimen Collection: / /

Patient's Last Name: _____	First Name: _____
Age: _____ Unit: <input type="checkbox"/> Years <input type="checkbox"/> Months	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Permanent Residence:	
Head of Household: _____	Village/Town: _____
District: _____	Chiefdom: _____ Mobile phone #: _____

Date Patient First Became Sick: / /

- Specimen/shipping instructions:**
- Label sample with **patient name, date of collection, and case ID**
 - Send sample cold with a **cold/ice pack, and packaged appropriately**
 - Collect whole blood in a purple top (EDTA) tube green or red top tubes acceptable if purple not available
 - Preferred** sample volume = **4ml** (minimum sample volume = 2ml)

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Has this patient had a sample submitted previously? Yes No Unk

Sample Type: Whole blood Skin biopsy

Post-mortem heart blood Other specimen type, specify: _____

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EBOLA Clinical Specimens and Laboratory Testing

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Sample 1

Date of Specimen Collection: / /

Patient's Last Name: _____	First Name: _____
Age: _____ Unit: <input type="checkbox"/> Years <input type="checkbox"/> Months	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Permanent Residence:	
Head of Household: _____	Village/Town: _____
District: _____	Chiefdom: _____ Mobile phone #: _____

Date Patient First Became Sick: / /

- Specimen/shipping instructions:**
- Label sample with **patient name, date of collection, and case ID**
 - Send sample cold with a **cold/ice pack, and packaged appropriately**
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Has this patient had a sample submitted previously? Yes No Unk

Sample Type: Whole blood Skin biopsy

Post-mortem heart blood Other specimen type, specify: _____

