Tennessee Department of Health

Viral Hemorrhagic Fever

Please fill out all three pages of this form as complete as possible. Anything that appears in **red** is not available for data entry into NEDSS. However, you may find those fields helpful in your investigation. Do not forget to IMMEDIATELY notify Central Office regarding this case.

DEMOGRAPHICS

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____

Reported Age: _____ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____ **E-mail:** _____

Ethnicity: □ Hispanic □ Not Hispanic **Race:** □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Other (_____)

Primary Language Spoken: _____ **Translator Needed:** □ Yes □ No **Country of Origin:** _____

Employer/School/Daycare: _____ **Occupation:** _____ □ **HCW?**

LAB REPORT

Reporting Facility: _____ **Ordering Facility:** _____

Ordering Provider: _____ **Phone Number:** _____

Jurisdiction: □ East Tennessee □ West Tennessee □ Jackson/Madison □ Mid-Cumberland □ Upper Cumberland □ Memphis/Shelby □ Northeast □ Nashville/Davidson □ Sullivan □ South Central □ Chattanooga/Hamilton □ Out of Tennessee □ Southeast □ Knoxville/Knox □ Unassigned

Lab Report Date: ____/____/_____
Date Received by Public Health: ____/____/_____
Date Specimen Collected: ____/____/_____

Specimen Source: □ Blood □ Plasma □ Tissue □ Other _____ □ Unknown

Resulted Test

□ Viral hemorrhagic disease virus RNA, by RT-PCR
□ Positive □ Negative □ Indeterminate □ Pending □ Unknown
□ Viral hemorrhagic disease virus identified, by Culture
□ Positive □ Negative □ Indeterminate □ Pending □ Unknown
□ Viral hemorrhagic disease virus antigens, by ELISA
□ Positive □ Negative □ Indeterminate □ Pending □ Unknown
□ Viral hemorrhagic disease virus antigens, by IHC
□ Positive □ Negative □ Indeterminate □ Pending □ Unknown
□ Viral hemorrhagic disease virus antibodies, IgG
□ Titer _____ □ Interpretation _____
□ Viral hemorrhagic disease virus antibodies, IgM
□ Titer _____ □ Interpretation _____

Organism

□ Crimean-Congo Hemorrhagic Fever virus
□ Ebola virus (Subtype: _____)
□ Lassa virus
□ Lujo virus
□ Marburg virus
□ New World Arenavirus - Guanarito virus
□ New World Arenavirus - Junin virus
□ New World Arenavirus - Machupo virus
□ New World Arenavirus - Sabia virus
□ _____

INVESTIGATION

Investigation Summary

Investigation Start Date: ____/____/_____
Investigation Status: □ Open □ Closed
Investigator: _____
Date Assigned to Investigation: ____/____/_____

Reporting Source

Date of Report: ____/____/_____
Reporting Source: _____
Earliest Date Reported to County: ____/____/_____
Reporter: _____

Clinical Information

Case Status: □ Confirmed □ Suspect □ Not a case
Is the patient pregnant?: □ Yes □ No □ Unknown
Did the patient die from this illness?: □ Yes □ No □ Unknown
***If yes*, Date of Death:** ____/____/_____
Morgue: _____
Funeral Home: _____

Did patient visit an outpatient medical provider since illness onset? □ Yes □ No □ Unknown

1

Type: □ Emergency Department □ Health Department □ Pharmacy □ Urgent Care □ Other _____
Facility Name: _____
City, State: _____
Date of Visit: ____/____/_____
Description: _____
Provider Name: _____
Provider Type: □ Nurse □ Physician Assistant □ Physician □ Other _____

2

Type: □ Emergency Department □ Health Department □ Pharmacy □ Urgent Care □ Other _____
Facility Name: _____
City, State: _____
Date of Visit: ____/____/_____
Description: _____
Provider Name: _____
Provider Type: □ Nurse □ Physician Assistant □ Physician □ Other _____

3

Type: □ Emergency Department □ Health Department □ Pharmacy □ Urgent Care □ Other _____
Facility Name: _____
City, State: _____
Date of Visit: ____/____/_____
Description: _____
Provider Name: _____
Provider Type: □ Nurse □ Physician Assistant □ Physician □ Other _____

INVESTIGATION (CONTINUED)

CLINICAL INFORMATION

Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown

1

Hospital: ________________________

Admission Date: ____/____/_______
Discharge Date: ____/____/_______

Discharged to: ____________________

Mode of Arrival: ☐ Personal Vehicle ☐ Ambulance ☐ Medevac Aircraft ☐ Other ____________

Arrival Date/Time: ___/___/_____ ____:____ ☐ AM ☐ PM

Admitted from: ☐ Home ☐ Other ☐ Another facility ________________

Location of Admission: ☐ ED ☐ ICU ☐ IMU ☐ Ward ______ ☐ Other ______

Isolation Date/Time: ___/___/_____ ____:____ ☐ AM ☐ PM

2

Hospital: ________________________

Admission Date: ____/____/_______
Discharge Date: ____/____/_______

Discharged to: ____________________

Mode of Arrival: ☐ Personal Vehicle ☐ Ambulance ☐ Medevac Aircraft ☐ Other ____________

Arrival Date/Time: ___/___/_____ ____:____ ☐ AM ☐ PM

Admitted from: ☐ Home ☐ Other ☐ Another facility ________________

Location of Admission: ☐ ED ☐ ICU ☐ IMU ☐ Ward ______ ☐ Other ______

Isolation Date/Time: ___/___/_____ ____:____ ☐ AM ☐ PM

3

Hospital: ________________________

Admission Date: ____/____/_______
Discharge Date: ____/____/_______

Discharged to: ____________________

Mode of Arrival: ☐ Personal Vehicle ☐ Ambulance ☐ Medevac Aircraft ☐ Other ____________

Arrival Date/Time: ___/___/_____ ____:____ ☐ AM ☐ PM

Admitted from: ☐ Home ☐ Other ☐ Another facility ________________

Location of Admission: ☐ ED ☐ ICU ☐ IMU ☐ Ward ______ ☐ Other ______

Isolation Date/Time: ___/___/_____ ____:____ ☐ AM ☐ PM

SYMPTOM HISTORY

Date/Time of... Illness Onset: ____/____/_______ ____:____ ☐ AM ☐ PM **Recovery:** ____/____/_______ ____:____ ☐ AM ☐ PM

Symptoms (check all that apply):	**Date of Symptom Onset:**	***If yes*, where were you?**	**Symptoms (check all that apply):**	**Date of Symptom Onset:**	***If yes*, where were you?**
☐ Abdominal pain	____/____/_______		☐ Red eyes	____/____/_______	
☐ Chest Pain	____/____/_______		☐ Skin rash	____/____/_______	
☐ Cough	____/____/_______		☐ Sore throat	____/____/_______	
☐ Diarrhea	____/____/_______		☐ Vomiting/Nausea	____/____/_______	
☐ Difficulty breathing	____/____/_______		☐ Bleeding not related to injury	____/____/_______	
☐ Difficulty swallowing	____/____/_______		☐ Nose bleed	____/____/_______	
☐ Fever (Max) ________°F	____/____/_______		☐ Blood in vomit	____/____/_______	
☐ Headache	____/____/_______		☐ Coughing up blood	____/____/_______	
☐ Hiccups	____/____/_______		☐ Bloody or black stool	____/____/_______	
☐ Intense Weakness	____/____/_______		☐ Other bleeding __________	____/____/_______	
☐ Muscle pain	____/____/_______		☐ Other __________________	____/____/_______	

EMERGENCY CONTACT INFORMATION

Last Name: ______________________ **First:** _____________________ **Relationship:** ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ Other (________________________)
Phone Number: __________________ **E-mail:** ____________________

Last Name: ______________________ **First:** _____________________ **Relationship:** ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ Other (________________________)
Phone Number: __________________ **E-mail:** ____________________

Last Name: ______________________ **First:** _____________________ **Relationship:** ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ Other (________________________)
Phone Number: __________________ **E-mail:** ____________________

Last Name: ______________________ **First:** _____________________ **Relationship:** ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ Other (________________________)
Phone Number: __________________ **E-mail:** ____________________

HOUSEHOLD PETS

Does the patient have any pets living in the household? ☐ Yes ☐ No ☐ Unknown

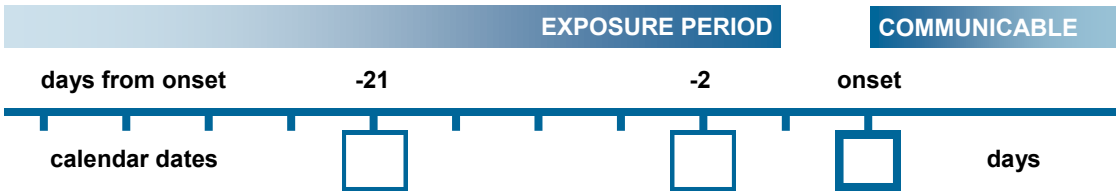
If yes, **Which kind?** ☐ Cat ☐ Dog ☐ Other (_________________________) **How many in total?** _________

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____

PSN1__ __ __ __ __ __ __**TN01** **CAS1**__ __ __ __ __ __ __**TN01** **State Lab Accession #:** _____

Infection Timeline

Enter onset date in heavy box. Count back to the figure probable exposure period. Ask about exposures between those dates.



Travel History

Did patient travel prior to onset of illness? □ Yes □ No □ Unknown

1	**Type:** □ Domestic □ International	**Destination 1:** _____ _____	**Mode of travel:**	□ Airplane □ Cruise	□ Bus □ Ship	□ Car □ Train
		Village/District: _____	**Date of Arrival:**	____/____/_____		
		Interim Stops: _____	**Date of Departure:**	____/____/_____		
2	**Type:** □ Domestic □ International	**Destination 1:** _____ _____	**Mode of travel:**	□ Airplane □ Cruise	□ Bus □ Ship	□ Car □ Train
		Village/District: _____	**Date of Arrival:**	____/____/_____		
		Interim Stops: _____	**Date of Departure:**	____/____/_____		

If more than 2 destinations, please specify here:

Did patient immigrate to the US within 21 days of illness onset?: □ Yes □ No □ Unknown

***If yes*, from which country?** _____

If patient traveled internationally, did they...				*Additional Details*
Travel in rural areas?	□ Yes	□ No	□ Unknown	
Travel in areas with known VHF cases?	□ Yes	□ No	□ Unknown	
Develop symptoms during travel?	□ Yes	□ No	□ Unknown ***If yes*, Location:** _____	
Develop symptoms while on an aircraft or at an airport?	□ Yes	□ No	□ Unknown ***If yes*, Name of Airport:** _____ **Airline:** _____ **Flight #:** _____	
Activities in country(ies) of travel or residence:	□ Medical provider □ Laboratory worker □ Other _____		□ Provided care for ill patient □ Administrator/Organizational	

Possible Source(s) of Infection During Exposure Period

Y	N	U	Exposure	*Additional Details*
□	□	□	Exposure to known or suspected VHF patients?	
□	□	□	Direct contact with known VHF patients without PPE?	
□	□	□	Exposure to blood products or bodily fluids from known VHF patients?	
□	□	□	Exposure to hospital settings known for treating VHF patients?	
□	□	□	Exposure to dead animals or “bushmeat” preparation or consumption?	
□	□	□	Visit caves inhabited by bats in VHF endemic country?	
□	□	□	Handled or touched dead body during funeral preparation or at funeral?	
□	□	□	Laboratory exposure to VHF specimens or animals (e.g., bats, rodents, primates) from VHF endemic countries?	
□	□	□	Received blood transfusion or organ transplant? *If yes*, date: ____/____/_____	

COMMENTS

TENNESSEE DEPARTMENT OF HEALTH

FOR ADMINISTRATIVE USE ONLY: DRAFT UPDATED 10/23/2014

Was the case interviewed by public health? □ Yes □ No □ Unknown

***If yes*, who provided the information?** □ Respondent □ Proxy □ Chart □ Other

***If Proxy or Other*, please specify:**

Name: _____ **Relationship:** _____

Date of Interview: ____/____/_____

Interviewer's Name: _____

Was the case entered into NBS? □ Yes □ No □ Unknown

Was the case entered into RedCAP? □ Yes □ No □ Unknown

Entry Dates: **NBS** ____/____/_____ **RedCAP** ____/____/_____