# Viral Hemorrhagic Fever

Agency: ____________

Investigator: ____________ Phone number: ____________

**FOR STATE USE ONLY**
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

## CASE

Last name: ____________
First and middle name: ____________
Maiden name: ____________ Suffix: ____________
Address line: ____________
Zip: ________ City: ____________
State: ________ County: ____________
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name: ____________

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other _____
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name: ____________
Parent/Guardian phone: ( )- - Type: ____________

## EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ____________
Exposure setting: ____________
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ________ Country: ________

**Healthcare provider information**

Last name: ____________
First name: ____________
Provider time: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name: ____________
Address line 1: ____________
Address line 2: ____________
Zip code: ____________ City: ____________
State: ____________ County: ____________
Phone : ( )- - Type: ____________

## LABORATORY FINDINGS

Laboratory: ____________ Accession #: ____________ Collection date: / /
Date received: / / Specimen source: ____________ Test type: ____________
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Type (e.g. serotype):

Laboratory: ____________ Accession #: ____________ Collection date: / /
Date received: / / Specimen source: ____________ Test type: ____________
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Type (e.g. serotype):

Laboratory: ____________ Accession #: ____________ Collection date: / /
Date received: / / Specimen source: ____________ Test type: ____________
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Type (e.g. serotype):

## OCCUPATIONS

**Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.**

Occupation type: ____________ Job title: ____________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________
Date worked from: ___/___/___ Address: ____________
Date worked to: ___/___/___ Zip code: ____________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ____________ State: ______ County: ______
Date removed: ___/___/___ Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown Health care worker type:

Occupation type: ____________ Job title: ____________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________
Date worked from: ___/___/___ Address: ____________
Date worked to: ___/___/___ Zip code: ____________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ____________ State: ______ County: ______
Date removed: ___/___/___ Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown Health care worker type:

## HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ____________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): ____________
Admission date: ___/___/___ Discharge date: ___/___/___ Days hospitalized: ____________
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

## CLINICAL INFO & DIAGNOSIS

**Symptoms:** ☐ Diarrhea ☐ Headache ☐ Malaise ☐ Renal failure ☐ Sore throat ☐ Fever ☐ Maculopapular rash ☐ Muscle pain ☐ Shock ☐ Vomiting

## OTHER LAB FINDINGS

**Thrombocytopenia**: ☐ Yes ☐ No ☐ Unknown **Lymphopenia:** ☐ Yes ☐ No ☐ Unknown

## TREATMENT

**Antivirals prescribed:** ☐ Yes ☐ No ☐ Unknown

Antiviral: ____________
Date started: ___/___/___
Dose: ____________
Unit: ☐ mg ☐ ml ☐ IU # of days: ______
# of times a day: ______ Route: ______

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Date started: ___/___/___
Dose: ____________
Unit: ☐ mg ☐ ml ☐ IU # of days: ______
# of times a day: ______ Route: ______

Antiviral: ____________
Date started: ___/___/___
Dose: ____________
Unit: ☐ mg ☐ ml ☐ IU # of days: ______
# of times a day: ______ Route: ______

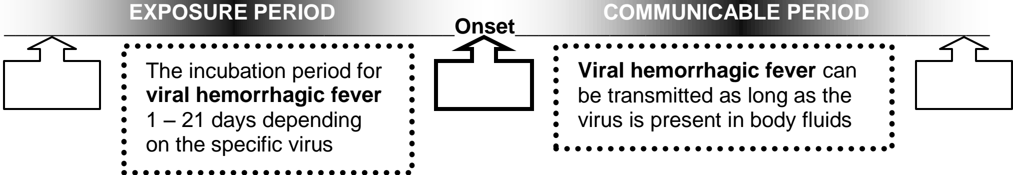
**Therapeutic medications prescribed?** ☐ Yes ☐ No ☐ Unk

List medications: ____________________________________________

____________________________________________

## INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.




## RISK FACTORS/TRAVEL

**Risk Factors/Travel Information – *In the 1 to 21 days prior to onset of symptoms did the case consume the following:***

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: ______________ Departure date: ___/___/___ Return date: ___/___/___

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ______ City: ______________ Departure date: ___/___/___ Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: ______________ Departure date: ___/___/___ Return date: ___/___/___

**Exposures – *In the 1 to 21 days prior to the onset of symptoms did the case have the following exposures:***

**Animal contact:** ☐ Yes ☐ No ☐ Unk Animal: ☐ Chimpanzees ☐ Gorillas ☐ Forest duikers ☐ Monkeys

**Exposed to potential infection sources:** ☐ Yes ☐ No ☐ Unk Possible VHF sources: ☐ Injected drugs ☐ Contact with blood or other body fluids ☐ Needle stick ☐ Contact with deceased person

NOTES: ____________________________________________