# Ebola Virus Disease Contact Tracing Form

<table>
<thead>
<tr>
<th>State/Local ID:</th>
<th>CDC ID:</th>
</tr>
</thead>
</table>

## I. Interview Information

*Date of interview: MM / DD / YYYY*

**Interviewer:**

Interviewer Name (Last, First): _____________________________________________________________

State/Local Health Department: ___________________________________________________________

Business Address: ______________________________________________________________________

City: __________________________ State: _______ Zip: __________ County: ________________

Phone number: ________________________ Email address: ________________________________

**Contact:**

Who is providing information for this form?

- [ ] Contact
- [ ] Other, specify person (Last, First): _________________________________________________
  
  Relationship to contact: _______________________________________________________________
  
  Reason contact unable to provide information: [ ] Contact is a minor [ ] Other _______________

Contact primary language: _____________________________

Was this form administered via a translator? [ ] Yes [ ] No

## II. Ebola Case Information (Case associated with Contact)

At the time of this report, is the patient?  [ ] Confirmed  [ ] Probable  [ ] Unknown

Date of illness onset of patient: MM / DD / YYYY

Notes:
### III. Contact Information

| Last Name: ______________________________ | First Name: ______________________________ |
| Home Street Address: ______________________ | Apt. # __________________ |
| City: ________________________ | County: _______________ | State: _______ Zip: _______________ |
| Time at current residence: ____________ |
| Previous address (if less than 1 month at current residence): |
| Home Street Address: ______________________ | Apt. # __________________ |
| City: ________________________ | County: _______________ | State: _______ Zip: _______________ |
| Country: ________________________ |
| Phone number: ________________________ | Email address: ______________________________ |
| Other Phone number or contact information: ______________________________ |

### IV. Contact Demographics

Date of birth: MM / DD / YYYY  Age: 

Sex:  □ Male  □ Female

What is your occupation? ________________________  □ If HCW that provided care to Ebola patient or worker (in any capacity including janitorial, lab, medical waste, food services, etc.) at a healthcare facility that treated Ebola patient, skip to Section VII now

Place of work and address: ______________________________

Do you have any pets in your household?:  □ Yes Give species and number_________________  □ No

NOTES:
# Ebola Virus Disease Contact Tracing Form

**State/Local ID:**

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## V. Exposure History

*Question assesses LOW exposure; †Question assesses HIGH exposure; ‡Question assesses casual contact or NO KNOWN exposure; Note: direct contact requires contact with skin and or mucous membranes.*

1) What is your relationship to the patient?  
- Partner/spouse  
- Family member  
- Co-worker  
- Friend/acquaintance  
- Classmate  
- Visited same healthcare facility/care area as Ebola patient  
- Neighbor/community member  
- Other ____________________________________________

2) *Do you live in the same house as the patient?  
- Yes  
- No  

3) Did you have any contact with the patient while he/she was ill?  
- Yes  
- No  
- Unsure  

If yes, please describe and provide dates of first and last contact (include description of any PPE used):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

4) †Did you have any contact with blood or body fluids from the patient while he/she was ill (including contaminated objects or surfaces such as bedding or clothing)?  
- Yes  
- No (skip to Q5)  
- Unsure  

If yes, what body fluids were you in contact with? (check all that apply)  
- Blood  
- Feces  
- Vomit  
- Urine  
- Sweat  
- Tears  
- Respiratory secretions  
- Semen  
- Vaginal fluids  
- Other, specify: ___________________________

Last date of contact: **MM / DD / YYYY** (Skip to Section VI)

5) *Were you within approximately 3 feet of the patient or within his/her room or care area for a prolonged period of time (at least one hour)?  
- Yes  
- No  
- Unsure  

If yes, date of last contact: **MM / DD / YYYY**

6) *Did you have any direct contact with the patient (e.g. shaking hands) no matter how brief?  
- Yes  
- No  
- Unsure  

Date of last contact: **MM / DD / YYYY** (Skip to Section VI)

7) ‡Did you have any casual contact with the patient (meaning a brief interaction, such as walking by him/her or being in the same room for a very short period of time) in which you did not directly touch him/her?  
- Yes  
- No  
- Unsure  

If yes, date of last contact: **MM / DD / YYYY**
VI. Activities During Period Of Exposure

Did you participate in any of the following activities with the patient while he/she was ill?

**Caregiving**
Did you take care of the patient when he/she was sick (e.g. bathe, feed, help to bathroom)?
- Yes
- No
- Unsure

Did you do house cleaning or provide indirect care for the patient (e.g. wash clothes or bedding, wash dishes)?
- Yes
- No
- Unsure

**Sharing Meals**
Did you eat meals with the patient?
- Yes
- No
- Unsure

Did you share utensils or a cup with the patient?
- Yes
- No
- Unsure

**Other close contact**
Did you use the same bathroom as the patient?
- Yes
- No
- Unsure

Did you sleep in the same room as the patient?
- Yes
- No
- Unsure

Did you sleep in the same bed as the patient?
- Yes
- No
- Unsure

Did you hug the patient?
- Yes
- No
- Unsure

Did you kiss the patient?
- Yes
- No
- Unsure

**Transportation**
Did you share any transport with the patient (car, bus, plane, taxi, etc.)?
- Yes
- No
- Unsure

If yes, give for all shared transport: Conveyance ___________________________ Dates of travel: _________

Name of airline and flight number: _____________________________________________

Origin: _____________________ Destination: ________________________________

Any transit points: _________________________________________________________

Notes:
Health Care Worker (HCW) Survey

VII. Healthcare Facility Information

Facility Name _________________________________  Facility Type____________________________  
Campus/Building ______________________________________________________________________ 
Address______________________________________________________________________________ 
City: ______________________  State: ________   Zip: _________County: _____________________  
Job title: _____________________________________________________________
Where is your primary site of work in the facility [e.g., specific ward(s), floor(s), department(s)]?________________________

VIII. HCW Exposure History*Question assesses LOW exposure; †Question assesses HIGH exposure; ‡Question assesses casual contact (NO KNOWN exposure)

1) Did you have any contact with the Ebola patient while he/she was ill? ☐ Yes  ☐ No  ☐ Unsure  If yes, please describe and provide dates of first and last contact:

2) *Were you within approximately 3 feet of the patient or within his/her room or care area for a prolonged period of time? (This includes while wearing PPE) ☐ Yes  ☐ No  (skip to Q3)  ☐ Unsure  If yes, what PPE was worn on these occasions? Check all that apply
☐Gloves  ☐Gown (impermeable)  ☐Eye protection (goggles or face shield)  ☐Facemask  ☐N95 or other respirator  ☐Body suit  ☐None  ☐Other________________________________________
If any PPE was worn, was donning of PPE witnessed? ☐ Yes Name:________________________________________  ☐ No  ☐ Unsure  
If any PPE was worn, was patient care witnessed?  ☐ Yes Name:________________________________________  ☐ No  ☐ Unsure  
If any PPE was worn, was doffing of PPE witnessed?  ☐ Yes Name:________________________________________  ☐ No  ☐ Unsure  
Last date(s) of exposure: MM / DD / YYYY  (Skip to Q4)
Ebola Virus Disease Contact Tracing Form

<table>
<thead>
<tr>
<th>IX. HCW Exposure History continued</th>
<th>*Question indicates LOW exposure; † Question indicates HIGH exposure; ‡ Question indicates casual contact (NO KNOWN exposure)</th>
</tr>
</thead>
</table>

3) ‡ Did you have any casual contact with the patient (meaning a brief interaction, such as walking by him/her or being in the same room for a very short period of time) in which you did not directly touch him/her? ☐ Yes ☐ No ☐ Unsure
   If yes, date of last contact: **MM / DD / YYYY**

4) * Did you have any direct contact** with the patient (e.g. shaking hands) no matter how brief?
   (This includes while wearing PPE) ☐ Yes ☐ No ☐ Unsure
   If yes, what PPE was worn on these occasions? Check all that apply
   ☐ Gloves ☐ Gown (impermeable) ☐ Eye protection (goggles or face shield) ☐ Facemask
   ☐ N95 or other respirator ☐ Body suit ☐ None
   ☐ Other __________________________________________

   If any PPE was worn, was donning of PPE witnessed? ☐ Yes Name: ____________________________
   ☐ No ☐ Unsure

   If any PPE was worn, was patient care witnessed? ☐ Yes Name: ____________________________
   ☐ No ☐ Unsure

   If any PPE was worn, was doffing of PPE witnessed? ☐ Yes Name: ____________________________
   ☐ No ☐ Unsure

Last date(s) of contact: **MM / DD / YYYY**
## Ebola Virus Disease Contact Tracing Form

**State/Local ID:**

**CDC ID:**

### X. HCW Exposure History cont’d

5) †Did you have any direct contact with blood or body fluids from the patient while he/she was ill (including contaminated objects or surfaces such as bedding or clothing)? (This includes while wearing PPE)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
</table>

If yes,

- What body fluids were you in contact with? (check all that apply)
  - Blood
  - Feces
  - Vomit
  - Urine
  - Sweat
  - Tears
  - Respiratory secretions (e.g. sputum, nasal mucus)
  - Saliva
  - Semen or vaginal fluids
  - Other, specify: ________________________________

- What PPE was worn on these occasions? Check all that apply
  - Gloves
  - Gown (impermeable)
  - Eye protection (goggles or face shield)
  - Facemask
  - N95 or other respirator
  - Body suit
  - None
  - Other ________________________________

- If any PPE was worn, was donning of PPE witnessed? □ Yes Name: ________________________________

- If any PPE was worn, was patient care witnessed? □ Yes Name: ________________________________

- If any PPE was worn, was doffing of PPE witnessed? □ Yes Name: ________________________________

Last date(s) of blood/body fluid exposure: MM / DD / YYYY
XI. HCW Exposure History cont’d

**NOTES:** Please describe any lapses in proper infection control practices that may have occurred during any of these contacts and describe what happened (e.g., inappropriate/ineffective disinfection; defective gloves, gowns, mask). Include hospital location (outpatient care, acute inpatient, ED, ICU, long-term care, clinical lab, dialysis center, etc.), response to breach, and duration of each occurrence:
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State/Local ID: ____________________________
CDC ID: ____________________________

Follow-up Actions:

☐ No further follow-up required. Does not meet criteria for high or low exposure or exposure was >21 days.
☐ Observed Fever Monitoring Recommended

☐ High risk exposure ☐ Low risk exposure

Last exposure date: MM / DD / YYYY  Last day of monitoring: MM / DD / YYYY

Who will conduct the follow-up for fever monitoring?

Name/Affiliation: ____________________________
Phone Number and Contact Information: ____________________________

☐ Self-Monitoring Recommended (for No Known Exposure only)

Last exposure date: MM / DD / YYYY  Last day of monitoring: MM / DD / YYYY

Who will conduct the follow-up for fever monitoring?

Name/Affiliation: ____________________________
Phone Number and Contact Information: ____________________________

☐ Respondent has had a fever or severe headache, muscle pain, diarrhea, vomiting, abdominal pain, unexplained hemorrhage (bleeding or bruising) since having contact with the patient

Temperature: ________ °F

Fever onset date: MM / DD / YYYY

Symptoms: ____________________________________________

Where will the patient be evaluated for fever? ____________________________
### XII. Contact Symptom Follow-Up Diary

<table>
<thead>
<tr>
<th>1 day after last exposure</th>
<th>2 days after last exposure</th>
<th>3 days after last exposure</th>
<th>4 days after last exposure</th>
<th>5 days after last exposure</th>
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<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
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</tbody>
</table>
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<th>State/Local ID:</th>
<th>CDC ID:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>11 days after last exposure</th>
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<tbody>
<tr>
<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
</tr>
</tbody>
</table>

- □ No symptoms
- □ Fever ________ °F
- □ Chills
- □ Weakness
- □ Headache
- □ Muscle Aches
- □ Abdominal Pain
- □ Diarrhea _____ times/day
- □ Vomiting
- □ Unexplained hemorrhage
- □ Other _______________

- □ No symptoms
- □ Fever ________ °F
- □ Chills
- □ Weakness
- □ Headache
- □ Muscle Aches
- □ Abdominal Pain
- □ Diarrhea _____ times/day
- □ Vomiting
- □ Unexplained hemorrhage
- □ Other _______________

- □ No symptoms
- □ Fever ________ °F
- □ Chills
- □ Weakness
- □ Headache
- □ Muscle Aches
- □ Abdominal Pain
- □ Diarrhea _____ times/day
- □ Vomiting
- □ Unexplained hemorrhage
- □ Other _______________

- □ No symptoms
- □ Fever ________ °F
- □ Chills
- □ Weakness
- □ Headache
- □ Muscle Aches
- □ Abdominal Pain
- □ Diarrhea _____ times/day
- □ Vomiting
- □ Unexplained hemorrhage
- □ Other _______________
### Ebola Virus Disease Contact Tracing Form

State/Local ID: ____________________________

CDC ID: ____________________________

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<th>16 days after last exposure</th>
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<td>□ Diarrhea ______times/day</td>
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<td>□ Unexplained hemorrhage</td>
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<td>□ Other ________________</td>
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</tbody>
</table>

Ebola Contact Tracing Form
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**State/Local ID:**

**CDC ID:**

## 21 days after last exposure

<table>
<thead>
<tr>
<th>Symptom</th>
<th>MM / DD / YYYY</th>
</tr>
</thead>
<tbody>
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<td>No symptoms</td>
<td></td>
</tr>
<tr>
<td>Fever ______ °F</td>
<td></td>
</tr>
<tr>
<td>Chills</td>
<td></td>
</tr>
<tr>
<td>Weakness</td>
<td></td>
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<tr>
<td>Headache</td>
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<tr>
<td>Muscle Aches</td>
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<tr>
<td>Abdominal Pain</td>
<td></td>
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<tr>
<td>Diarrhea ______ times/day</td>
<td></td>
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<tr>
<td>Vomiting</td>
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<tr>
<td>Unexplained hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Other ________________</td>
<td></td>
</tr>
</tbody>
</table>

**NOTES:**

- 21 days after last exposure
- MM/DD/YYYY
- No symptoms
- Fever ______ °F
- Chills
- Weakness
- Headache
- Muscle Aches
- Abdominal Pain
- Diarrhea ______ times/day
- Vomiting
- Unexplained hemorrhage
- Other ________________
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