Ebola Virus Disease Contact Tracing Form

State/Local ID: CDC ID:

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:

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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:

I

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

☐No ☐Unsure

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

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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:

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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)

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IX. HCW Exposure History continued **Question indicates LOW exposure; †Question indicates HIGH exposure; ‡Question indicates casual contact (NO KNOWN exposure)*

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

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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)

☐Yes ☐No ☐Unsure

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:_____

☐ 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 blood/body fluid exposure: MM / DD / YYYY

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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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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? _____

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XII. Contact Symptom Follow-Up Diary

1 day after last exposure MM / DD / YYYY	2 days after last exposure MM / DD / YYY	3 days after last exposure MM / DD / YYYY	4 days after last exposure MM / DD / YYYY	5 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 ________________	□ 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 ________________

6 days after last exposure MM / DD / YYYY	7 days after last exposure MM / DD / YYYY	8 days after last exposure MM / DD / YYYY	9 days after last exposure MM / DD / YYYY	10 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 ________________	□ 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 ________________

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11 days after last exposure MM / DD / YYYY	12 days after last exposure MM / DD / YYYY	13 days after last exposure MM / DD / YYYY	14 days after last exposure MM / DD / YYYY	15 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 _______________	◻ 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 _______________

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16 days after last exposure MM / DD / YYYY	17 days after last exposure MM / DD / YYYY	18 days after last exposure MM / DD / YYYY	19 days after last exposure MM / DD / YYYY	20 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 ________________	□ 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 ________________

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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 _____

NOTES:

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State/Local ID:

CDC ID:

NOTES: