COUNTY OF LOS ANGELES
Public Health

Acute Communicable Disease Control
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EBOLA VIRUS DISEASE PUI/CASE COMPREHENSIVE INTAKE FORM

ACDC Use Only

FORM A

Interviewer Last Name. First Name:	Interviewer Title:	Interviewer Phone Number:	Interview Date:

I. DEMOGRAPHIC INFORMATION

Individual's Last Name. First Name	Date of Birth:	Age Yr Mo	Sex:	LAC Resident? __ Yes __ No __ Unk

IRIS ID:	Pregnant? __ Yes __ No __ Unk	Estimated Delivery Date:	Last Date of Menstrual Cycle:

Weight (lbs):	Height:	Address- Number, Street, Apt #:	City:	State:	ZIP Code	Citizenship:

Cell Phone:	Home Phone:	Email Address:

Type of Residence: Apartment Condo House Mobile Home __ Town House __ Hotel __ Congregate Setting (specify): _____

Are there pets in the household? Yes No Unknown
If Yes, Specify species and number. _____

Race: American Indian/Alaska Native Asian Black/African American White Native Hawaiian/Other Pacific Islander Unknown Other:

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Unknown

Previous address (if less than 1 month at current address):	City:	State/Area/Region:	ZIP Code:

Occupation:	Country of Permanent Residence:	Primary Language:	Translator needed? Yes No	Passport Number:

Is the individual working for nonprofit organization (NGO)? Yes No
If Yes, name of the NGO:
Was deployed to work in the EVD affected/endemic areas? Yes No

NGO Contact Name:	NGO Contact Telephone Number:	NGO Contact Email Address:

Work/school location and address:	Work/school Phone:

Occupation Setting: __ Health Care __ Emergency Medical Services __ Laboratory __ Residential Facility __ Childcare/School __ Food Service __ Institution (Correctional Facility, Drug Treatment Center, Homeless Shelter, Military Facility) __ Other. _____

Emergency Contact Name (Last, First):	Relationship:	Email:

Cell Phone:	Home Phone:	Contact has Access to Residence? __ Yes __ No

Who is providing information for this form? __ Patient __ Proxy __ Contact __ Other	If not patient, Provide Name (Last, First):	Relationship to Patient:

Cell Phone:	Email:	Reason of Not Patient:

II. MEDICAL PROVIDER INFORMATION

Primary Care Provider Name:	Primary Care Provider Phone Number:

Insurance:	Insurance Number:

Hospital/Clinic the individual visits for urgent medical care:	Hospital/Clinic urgent medical care Phone Number:

III. SYMPTOMS & VACCINATION

Previously Diagnosed with EVD? Yes No Unk If yes, when?	Laboratory Confirmed? Yes No Unk

Received EVD Vaccination? Yes No Unk If yes, when?	
Received Malaria Chemoprophy? __ Yes __ No __ Unk If yes, when?	
Received Yellow Fever Prophylaxis? Yes No Unk If yes, when?	
Received COVID-19 Vaccination? Yes No Unk If yes, when?	Received Flu Vaccination? Yes No If yes, when?

Do you currently have the following Symptoms and Signs (check all that apply)? [Ebola Symptoms on CDC Website]

If any checked, specify earliest onset date:

Fever (≥ 100.4° F/38.0° C) Highest Recorded:

Severe Headache	Sore Throat	Skin Rash – describe in Other Symptoms
Aches and Pains / Muscle pain	Loss of Appetite	__ Unexplained Hemorrhaging/ Bruising (specify site in Other Symptoms)
Arthralgia / Joint pain	Abdominal Pain	__ Unexplained Bleeding (not related to injury)/ Hemorrhage internally or externally
Weakness	Diarrhea	__ Bloody Cough __ Black or bloody stool __ Nosebleed __ Bloody Diarrhea
Fatigue	Vomiting (Describe where vomited and if cleaned up by who in Other Symptoms)	__ Vomiting Blood __ Purpuric Rash __ Blood in Urine __ Other:

__ Other Symptoms:

Person Currently Has: **Dry Symptoms** **Wet Symptoms** **Expired, Date of Death:**

Patient Name (Last, First) _____ Date of Birth _____ IRIS:_____

IV. CLINICAL INFORMATION (COMPLETE IF CASE IS/WAS HOSPITALIZED FOR EVD)

If Case was Reported by a Medical Facility, complete the bellow. If Not, Skip to Present Illness:

Reporter Name:	Title:	Reporter Phone:	Date of Report:
Facility Name:		Facility Address:	
Physician Name:	Physician Phone:	Physician Pager:	
Infection Preventionist Name:		Infection Preventionist Phone:	

PRESENT ILLNESS

Visited Any Health Care Facility (s)? __ Yes, List Facility Names and Date of Visit __ No, Skip to Laboratory Information

Health Care Facility:	City:	Date of Visit:
Health Care Facility:	City:	Date of Visit

Onset date	Hospitalized? Yes No	Hospital Name	Medical Record Number
Point of Contact of Hospital (Last name, First name, Title)		Phone:	Email:

Admit Date:	Discharge Date:	Discharge Diagnosis:

Patient Room number(s):	Current Patient Room Phone Number:	Is the Patient in an Isolated Room? Yes No	In ICU? Yes No	Intubated? Yes No

Current Disposition? ED Admitted Expired, Date Expired: AMA Recovered Unknown

Malaria Prophylaxis Yes No Unk | Yellow Fever Prophylaxis Yes No Unk

Treatment/ Procedure Provided:

Medication Prescribed:

Immunocompromised: __ Yes __ No __ Unk | Significant Medical History:

LABORATORY INFORMATION

Test Type	Test Performed?	Collection Date	Result
Malaria Smear	__ Yes __ No __ Unk		
Malaria PCR	Yes No Unk		
Influenza PCR	Yes No Unk		
Cholera Stool Culture	Yes No Unk		
Typhoid Fever Culture	__ Yes __ No __ Unk		
WNV PCR	Yes No Unk		
Rift Valley Fever	Yes No Unk		
COVID-19 PCR	Yes No Unk		
Blood Culture	__ Yes __ No __ Unk		
CBC/other Blood Test	Yes No Unk		WBC (c/uL): Hgb/Hct (mg/dL): Platelets (<150,000): PT/PTT:
Liver Function	Yes No Unk		ALT (SGPT): AST (SGOT):
Renal Function	Yes No Unk		Creatinine: BUN:

Specify Other Abnormal Laboratory Findings:

Any Specimens Collected for Possible Ebola Virus or Marburg Virus Ruel-Out Testing?

__ Yes, mark the specimens collected below No, skip to Section V

	Test Method	Ebola Virus Result	Marburg Virus Result	Other Test:
Whole Blood, Collection Date:				
Other: _____, Collection Date: _____				

V. ASSESSMENT CATEGORY AND FORM INSTRUCTIONS

Did you have **potential exposure** to the following?

__ Exposure to confirmed or suspect case of EVD in the United States (US) in the last 21 days.

__ Traveled in the EVD Affected/Endemic Areas in the last 21 days. *(Start at Travel section V. and complete rest of form.)*

VI. EXPOSURE TO KNOWN CASE (CONFIRMED OR SUSPECT) IN UNITED STATES

Known EVD Case Name (Last, First): _____ IRIS ID # (if applicable) :_____

Current Case Status: __ Confirmed __ Suspect __ Unknown Symptom Onset Date:

1. Contact's First Date of Exposure to the Known EVD Case: _____
2. Contact's Last Date of Exposure to the known EVD Case: _____
3. Did the person have exposure with the known EVD patient while they had symptoms? __ Yes __ No __ Unknown
4. What is the person's relationship to the EVD patient? __ Household Member __ Healthcare Worker __ EMS __ Friend __ Sexual Partner __ Work/School __ Shared Transportation __ Other, Specify: _____

*(Only skip Travel section VII.& complete rest of form, if person did **NOT** travel)*

VII. TRAVEL

1. **Did the person travel to the Ebola Virus Disease (EVD) Affected/Endemic Areas?** __ Yes No, skip to section VIII __ Unknown
2. If Yes, Last date in the Ebola Virus Disease (EVD) Affected/Endemic Area(s)? _____
3. Affected/Endemic Area(s) visited: Democratic Republic of the Congo | Guinea | Liberia Sierra Leone Uganda Other:
4. List the City/District the person visited:
5. Reason for travel: Business Vacation | Visiting family Permanent residence Ebola-response activities (describe in Usual Activities) Other, provide details:
6. Type of lodging used during stay: Hotel Relative/Friend's home | Work Lodging Other, provide details: _____

Usual Activities while in EVD Affected/Endemic Area(s):

Patient Name (Last, First) _____ Date of Birth _____ IRIS:_____

VII. TRAVEL (continued)

Specify the person's travel itinerary to and/or from the Affected/Endemic Area(s) below.

Departure From (Country, City/Region)	Departure Date	Destination (Country, City/Region)	Arrival Date	Airline	Flight No.

4. Did the person directly handle bats, rodents or primates from the Affected/Endemic Areas? Yes No Unknown

If Yes, Place of contact. | Last date of exposure:

Type of Animal: Bats Rodents | Nonhuman Primates Other:

5. Was the person near anyone who was sick with EVD symptoms (signs of fever, vomiting, diarrhea, OR unexplained bleeding)?

Yes No Unknown

If Yes, Explain

If the individual was not in the area with Ebola outbreak AND did not have any exposure to a person with EVD, no further investigation is needed. Provide the education on section XVI of this form.

If the individual was in the area with Ebola outbreak and/or had exposure to person with EVD, proceed to the next section and complete the form.

VIII. HOUSEHOLD EXPOSURE

6. **Did the person live in same household with a suspect or known EVD patient while they were symptomatic?** Yes No Unknown

(*If No, skip to next Healthcare Exposure section VII.)*

If Yes, where was household exposure? in US in Affected/Endemic Areas

Last date of household exposure: _____

7. Did the person do any of the following: (Check all that apply)

Yes	No	Exposure
		Attend to the patient's direct care in a household setting (bathe, feed, help to bathroom, etc.)
		Attend to the patient's indirect care in a household setting (laundry, wash dishes, clean patient's room)
		Visit EVD patient's household (no direct or indirect care) only. If Yes, Describe visit. _____

IX. HEALTHCARE EXPOSURE

8. **Did the person visit or work in a healthcare facility or other healthcare setting?** Yes No Unk *(If No, skip to next Funeral section VIII.)*

If Yes, Specify facility/setting. _____

Where was the healthcare exposure? in US in Affected/Endemic Areas

Was the facility an Ebola Treatment Unit (ETU)? Yes No Unk If Yes, what zone(s) did you enter: Red Yellow Green

Specify date(s) of last exposure in each zone. _____

First and Last date of healthcare exposure? First Date: Last Date:

Ongoing exposure (ex. US HCW to an EVD patient)? Yes No

Work title (if applicable): Physician Nurse Lab Personnel Emergency Medical Service Observer

Other: Specify. _____

Nature of job duties:

_____

Were there any patients with EVD at that facility/setting? Yes No Unknown

9. Did the person have any of the following types of exposures to a suspect or known EVD patient while they were symptomatic? (*Check all that apply.)*

Yes	No	Exposure
		Provide direct care to a suspect or known EVD patient in a hospital/outpatient setting (physician, nurse, EMS, etc)
		Present in a room where aerosol generating procedure was done on a known EVD patient.
		Perform laboratory services (phlebotomy, other sample collection, laboratory testing, etc.)
		Perform custodial services (launder linens, disinfect equipment, clean an EVD patient's room)
		Attend to an EVD patient's food service needs (deliver food tray to room, pick up food tray, etc.)
		Perform an autopsy, surgery, or other medical examination

10. Did the person have exposure to blood or other body fluid(s) from a suspect or known EVD patient while they had symptoms? (include exposures while wearing person protective equipment (PPE) Yes No Unknown

If Yes, Explain how. _____

What body fluid(s) was the person exposed to? (Check all that apply)

Blood Saliva Tears Vomitus Sweat Cerebral spinal Respiratory/ Nasal secretion

Stool Urine Breast milk Semen Vaginal fluid Other, Specify:

IX. HEALTHCARE EXPOSURE (CONTINUED)

11. Did the person use personal protective equipment (PPE)? Yes No Unknown

If Yes, specify type of PPE used? (Check all that apply)

Single glove
Double gloves
Extended cuffs/ sleeves
Coveralls (body suit):
with integrated hood
without integrated hood
Surgical scrub suit
Gown (fluid resistant & impermeable)
Apron (fluid resistant/waterproof)
Head hood extending to shoulders
Surgical Mask
N95 Respirator
Powered Air-Purifying Respirator (PAPR) with full cowl or hood.
Face shield
Eye goggles
Leg covers
Shoe covers
Boot covers (extends at least to mid-calf)
Other:

Was the following witnessed? Donning of PPE Yes No Unknown If Yes, by whom? Name:_____
Patient Care Yes No Unknown If Yes, by whom? Name:_____
Doffing of PPE? Yes No Unknown If Yes, by whom? Name:_____

Did the person wear the same PPE items for every single encounter with the EVD patient? Yes No

If No, Which items were not worn consistently? _____

Describe any contact the person had without PPE or any breaks in PPE. _____

12. What was the person's type of exposure with the body fluids? *(Check all that apply)*

Contact with appropriate PPE only
Contact with intact skin
Contact with broken skin *(fresh cut, burn, abrasion that had not dried)*
Contact with mucous membranes *(splashes to eyes, nose, mouth, etc.)*
Contact via a needle stick *(percutaneous)*
Other: Specify. _____

X. FUNERAL EXPOSURE

13. **Did the person attend or participate in a funeral or funeral preparation for a suspect or known EVD patient? Yes No Unknown**

(*If No, skip to next Other Exposure section IX.)*

If Yes, where was funeral exposure? in US | in Affected/Endemic Areas

Last date of funeral exposure? _____

14. Did the person do any of the following: (Check all that apply.)

Yes	No	Exposure
		Prepare, or help prepare, the body for funeral/burial services (e.g., wash, embalm, or dress the body)
		Have other ****direct contact** with the body during funeral/burial services
		Only attend funeral/burial services (no direct contact with the body)

15. Was there direct exposure to the human remains without appropriate Personal Protective Equipment (PPE)? Yes No Unknown

Washing body Preparing body Other direct contact with body/fluids. Specify. _____

XI. OTHER EXPOSURES

16. **Did the person do any of the following with a suspect or known EVD patient while they were symptomatic?** *(Check all that apply.)*

Yes	No	Exposure
		Share Transportation: Plane | Train Uber/Lyft/Other Taxi Bus Ambulance | Other: _____ Length of time (hours):_____ Specify dates. _____
		Attend the same school/daycare class/office. If Yes, Last date exposed:
		^^Close contact in households/healthcare facilities/community settings *(see Important Terms section XIII.)* Last date exposed:
		Brief direct contact *(e.g., shaking hands)* with an EVD patient in the early stage of disease **without** appropriate PPE Last date exposed:
		Brief proximity *(e.g. being in the same room for a brief period of time)* with a symptomatic EVD patient Last date exposed:
		Other: Specify what and dates: Date: Date:

Patient Name (Last, First) _____ Date of Birth _____ IRIS:_____

XII. RISK CLASSIFICATION

Please Refer to CDC Guidance for Most Current Updates: https://www.cdc.gov/quarantine/interim-guidance-risk-assessment-ebola.html

High Risk Exposure - check if includes any of the following:

Present in designated Ebola outbreak area of the affected country within the previous 21 days.

Percutaneous (e.g., needle stick, piercing of the skin), mucous membrane exposure (e.g., eye, nose or mouth), or skin contact with blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen) from a person confirmed with Ebola while the person was symptomatic or suspected EVD.

Direct contact with person who has known or suspected EVD.

Providing health care to a patient with known or suspected EVD without use of recommended PPE, or experiencing a breach in infection control precautions that results in the potential for percutaneous, mucous membrane, or skin contact with the blood or body fluids of a patient with EVD while working in an Ebola treatment hospital or associated facility (e.g., laboratory) or while taking care of a patient with EVD

Direct contact with or the occurrence of a breach in infection control precautions while handling a dead body in an Ebola outbreak area, the body of a person who died of EVD or had an illness compatible with EVD, or who died of unknown cause after any potential exposure to Ebola virus

Direct contact **without** appropriate PPE with a person with Ebola while the person was symptomatic or person's body fluids.

Lab processing of blood or body fluids from a person with Ebola while the person was symptomatic **without** appropriate PPE or standard biosafety precautions.

Direct contact with a dead body **without** appropriate PPE in a country with widespread transmission or a country with cases in urban settings with uncertain control measures**.

Living in the same household as a person with symptomatic known or suspected EVD.

Medium Risk - check if includes any of the following:

Present in designated Ebola outbreak area of the affected country within the previous 21 days without high risk exposure.

Low (but not zero) Risk - check if includes any of the following:

Present in an affected country, but NOT in the designated Ebola outbreak area within the previous 21 days without high risk exposures

XIII. PUBLIC HEALTH ACTIONS (For details see B-73)

	Monitoring	Isolation/ Quarantine	Restricted/ Controlled Movement	Travel During Monitor	Travel by Commercial Transport
High	Active Monitoring Daily	Yes	Yes	Not permitted	Not permitted
Medium	Active Monitoring twice weekly	No	No	Advance notification to LAC DPH and notification/ coordination with destination health department	Permitted
Low	Active Monitoring once weekly	No	No	Advance notification to LAC DPH and notification/ coordination with destination health department	Permitted
No Risk	No further PH follow-up				

Does the person have travel plans outside of LAC during their daily symptom monitoring period? Yes No If Yes, Provide details.

Departure From (City/State/Country)	Departure Date	Destination (City/State/Country)	Arrival Date	Mode of Transportation (Airline, bus, private car, etc)	Carrier Name/Flight no.

Respondent refusing follow-up

Respondent has had a fever or other EVD symptom(s) since having exposure.

When evaluated?

XIV. INVESTIGATOR

Investigator's Name (print):	Investigator's Signature:	Phone number:

Health District:	Interview Date:

XV. EDUCATION

__ **Inform the individual that there are specialized hospitals that screen and treat for Ebola, and prior approval for transportation to and treatment at these hospitals must be obtained from LAC DPH. Thus, it is important to notify LAC DPH if he/she feels unwell as early as possible.**

Inform the individual that if he/she needs medical attention, a special ambulance will be used to transport patient to hospital. Family members may not ride in the ambulance due to safety and infection control concerns.

__ **If the individual is under 18 years old, inform the parents/guardian that they cannot ride with their child in the ambulance due to safety and infection control concerns. In addition, let the parents/guardian know that there may be some visitation restrictions per hospital policy.**

Inform individual that healthcare workers will be wearing PPE while they attend the individual. This may include gowns, hoods, masks, face shields and gloves.

There may be a special visitor restrictions at the hospital, depending on hospital policy.

Inform the individual to refrain from posting anything related to their medical condition (i.e. symptoms) on social media. This may hinder or delay medical care and can compromise their health privacy.

Inform the individual that if he/she needs medical attention at a specialized hospital, he/she should not to wear/bring expensive/valuable items (e.g. jewelry, electronics). These items may need to be decontaminated and could be either damaged or may not be returned for safety and contamination concerns.

Inform the individual to bring any medications or the list of the medications that he/she is taking when medical attention is needed at a specialized hospital.

If not already obtained, LAC DPH will interview the individual to obtain further information such as contacts who may have been exposed to the individual.

Please create a go bag (items <u>may not be returned</u> to individual)

- **Copy of photo ID card**
- **List of emergency contacts**
- **Work information**
- **Medication list**
- **Clothes and replaceable personal items**

If possible, create a plan of who can take care of the individual's family members and pet(s) and have a list of their contacts and caregiver contacts readily available.

- **Inform individual that, if needed, DPH will coordinate decontamination of the residence.**

For life threating emergencies, call 911 and inform of recent exposure to Ebola and symptoms.

XVI. IMPORTANT TERMS

EVD Affected/Endemic Areas include several African countries. Please check the CDC website for current outbreaks: https://www.cdc.gov/vhf/ebola/outbreaks

** Direct contact: means physical contact with a person with EVD (alive or dead) or with objects contaminated with the body fluids of a person with EVD (alive or dead) while not wearing recommended PPE.

^^ Close contact: Defined as being within approximately 3 feet of a person with Ebola while the person was symptomatic for a prolonged period of time while not using appropriate PPE.

Personal Protective Equipment (PPE): Follow the CDPH Ebola PPE Guidance https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/CDPH-PPE-Guidance-EVD.aspx