

# NJDOH EBOLA INVESTIGATION WORKSHEET

CDRSS #: \_\_\_\_\_

<b>Patient Last Name</b>	<b>First Name</b>	<b>DOB:</b> ____ / ____ / ____	<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
<b>Patient Address</b>		<b>County</b>	<b>Phone</b>
<b>Race</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Unknown			
<b>Occupation</b>		<b>Industry / work setting</b>	
<b>Was patient hospitalized because of this illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hospital: _____ Admit: ____ / ____ / ____ Discharge: ____ / ____ / ____		<b>Did the patient die because of this illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of death: ____ / ____ / ____	
<b>Physician Contact Information</b> Name: _____ Address: _____ Phone: _____ Fax: _____ E-mail: _____		<b>Hospital Laboratory Contact Information</b> Name: _____ Address: _____ Phone: _____ Fax: _____ E-mail: _____	
<b>Signs &amp; Symptoms</b>			<b>Onset Date</b>
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Fever (≥100.4°F): _____ °F	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Unexplained hemorrhage (bleeding or bruising)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	
Other symptoms/underlying medical conditions, <i>describe</i> :			
<b>Risk Factors (Ask all of these questions for the 21 days preceding illness onset or diagnosis)</b>			
List of areas with active Ebola virus transmission can be found at: <a href="https://www.cdc.gov/vhf/ebola/outbreaks/index-2018.html">https://www.cdc.gov/vhf/ebola/outbreaks/index-2018.html</a>			
Did patient have close contact with sick person(s) who recently in an area with active Ebola virus transmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Describe contact: Date(s):		
Did the patient attend a funeral in an area with active Ebola virus transmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Date(s):		
Did the patient have contact with semen from a man who recovered from Ebola virus disease (through oral, vaginal or anal sex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Date(s):		

Did the patient have direct contact with blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, semen) of a person who was sick with or who died from Ebola virus disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Specify body fluid(s): Date(s):				
Did the patient have direct contact with fruit bats or nonhuman primates (e.g., apes, monkeys) in an area with active Ebola virus transmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Date(s):				
Did the patient have direct contact with objects contaminated with body fluids from a person sick with Ebola virus disease or have direct contact with the body of a person who died from Ebola virus disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Specify objects and body fluid(s): Date(s):				
Did the patient work in a laboratory where Ebola specimens were handled or in a clinical laboratory in an area with active Ebola virus transmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Date(s):				
Was the patient a caregiver for an Ebola patient or healthcare worker in an area with active Ebola virus transmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Date(s):				
Was the patient in an area with active Ebola virus transmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Location(s): Date(s):				
Describe other exposures and what (if any) PPE was used:					
<b>Diagnostic Testing: ENTER RESULTS IN "COMMENTS &amp; TEST RESULTS" SECTION; SEND COPIES TO NJDOH/CDS</b>					
<b>Name of Test</b>	<b>Performed?</b>	<b>Date of specimen collection</b>	<b>Name of Test</b>	<b>Performed?</b>	<b>Date of specimen collection</b>
Malaria	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		CBC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		Chemistry	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
Blood culture	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		PT/INR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
Urine analysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		Other testing, specify:		
<b>Contacts</b>					
<b>List household contacts and other close contacts of patient</b>					
<b>Name</b>	<b>Date of Birth</b>	<b>Relationship</b>	<b>Phone</b>		
	___ / ___ / ___				
	___ / ___ / ___				
	___ / ___ / ___				
	___ / ___ / ___				
	___ / ___ / ___				
<b>Does patient live with any pets (e.g., dogs, cats, pigs)?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Specify number and type of animal(s):				
<b>Comments &amp; Test Results (add additional sheets if necessary)</b>					

Submit with all test results via encrypted email to [CDSVectorTeam@doh.nj.gov](mailto:CDSVectorTeam@doh.nj.gov) or fax to 609-826-4874.  
Questions? Call 609-826-5964