MARBURG INVESTIGATION SUMMARY

MR #: _____ **CDRSS #:** _____

Demographics			
Patient Last Name **First Name**		**DOB:** ____ / ____ / ____	**Phone number**
Address		**City**	**Municipality**
Ethnicity Hispanic / Non-Hispanic / Unknown	**Race** White Black Asian Pacific Islander American Indian or Alaskan Native / Unknown		
Occupation		**Industry / work setting**	
Is the patient a resident of the United States? Yes No Unk	**If patient is a non-US resident, where is the patient residence?** **Country:** **District/County:** **City:**		

Physician and Facility Information	
Was patient hospitalized because of this illness? Yes No Unk Hospital: _____ Admit: ___ / ____/ ___ Discharge: ___ / ____/ ___	**Did the patient die because of this illness?** Yes No Unk If yes, date of death: _____ / _____ / _____
Treating physician Name: Address: Phone: Fax: Email:	**Hospital Laboratory Contact Information** Name: Address: Phone: Fax: Email:

Clinical Status

Where was the patient when their symptoms first began?

Country: State:

District/County: City:

Sign/Symptom	Response	Onset Date	Additional required information
Abdominal pain	Yes No Unk	___ /___ /_____	
Anorexia	Yes No Unk	___ /___ /_____	
Chest pain	Yes No Unk	___ /___ /_____	
Chills	Yes No Unk	___ /___ /_____	
Conjunctivitis	Yes No Unk	___ /___ /_____	
Cough	Yes No Unk	___ /___ /_____	
Diarrhea	Yes No Unk	___ /___ /_____	
Difficulty breathing	Yes No Unk	___ /___ /_____	
Fatigue	Yes No Unk	___ /___ /_____	
Fever (≥100.4°F)	Yes No Unk	___ /___ /_____	Temperature: _____°F

Sign/Symptom	Response	Onset Date	Additional required information
Headache	Yes No Unk	___ /___ /_____	
Hiccups	Yes No Unk	___ /___ /_____	
Myalgia	Yes No Unk	___ /___ /_____	
Nausea	Yes No Unk	___ /___ /_____	
Organ failure	Yes No Unk	___ /___ /_____	
Pharyngitis (sore throat)	Yes No Unk	___ /___ /_____	
Rash	Yes No Unk	___ /___ /_____	Describe:
Sepsis	Yes No Unk	___ /___ /_____	
Unexplained hemorrhage (bleeding or bruising)	Yes No Unk	___ /___ /_____	Describe:
Vomiting	Yes No Unk	___ /___ /_____	
Weakness	Yes No Unk	___ /___ /_____	

Other symptoms/underlying medical conditions, *describe*:

Alternate Diagnosis:

Is patient immunocompromised due to medical condition(s) or treatment(s)?

Yes No Unk

If yes, specify medical condition/treatment:

Asplenic

Significant primary immunodeficiency disorders

Advanced, poorly-controlled or untreated HIV

Certain cancers, like leukemia, multiple myeloma and other cancers that impact how the immune system functions

Chemotherapy for cancer

Immunosuppressive therapy for an autoimmune disorder (e.g., rheumatoid arthritis) or post-transplant

Long-term (>14 days) corticosteroids (e.g., dexamethasone, prednisone, prednisolone, or methylprednisolone)

Other: _____

Is patient pregnant?

Yes No Unk

If yes, how many weeks/months pregnant?

_____ weeks _____ months

Is patient breastfeeding?

Yes No Unk

RISK FACTORS (Ask all of these questions for the 21 days preceding illness onset or diagnosis)	
Was the person in an area with active Marburg virus transmission? Yes No Unk	Location: Reason for visit/nature of travel: Date(s):
Did the person have close contact with a sick person(s) who was recently in an area with active Marburg virus transmission? Yes No Unk	Describe contact: Specify any PPE used: Date(s):
Was the person a caregiver for a Marburg patient, or were they a healthcare worker in an area with active Marburg virus transmission? Yes No Unk	Location: Describe contact: Specify any PPE used: Date(s):
Did the person have direct contact with the body of a person who was sick with or who died from Marburg, or did they have direct contact with blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, semen) or objects contaminated by body fluids of a person who was sick with or who died from Marburg? Yes No Unk	Specify contact: Date(s):
Did the person have contact with semen from a person who had or has Marburg (through oral, vaginal or anal sex)? Yes No Unk	Specify contact: Date(s):
Did the person attend a funeral or perform burial work in an area with active Marburg virus transmission? Yes No Unk Did deceased have or may have had MVD? Yes No Unk	Describe participation in funeral/burial work: Date(s):
Did the person work or spend time in a mine or cave in an area with active Marburg transmission? Yes No Unk	Specify: Location: Date(s):
Did the person have direct contact with fruit bats or nonhuman primates (e.g., apes, monkeys) or their feces in an area with active Marburg virus transmission? Yes No Unk	Specify animal and contact: Location: Date(s):
Did the person consume any meat harvested from wild animals (bushmeat) in an area with active Marburg transmission? Yes No Unk	Specify meat and how it was cooked: Location: Date(s):
Did the person work in a laboratory where Marburg specimens were handled or in a laboratory located in an area with active Marburg virus transmission? Yes No Unk	Describe work: Location: Date(s):

Did the person visit a health care facility or traditional healer in an area with active Marburg virus transmission? Yes No Unk	Reason for visit: Location: Date(s):

Describe other exposures and what (if any) PPE was used:

DIAGNOSTIC TESTING

Name of Test	**Performed?**			**Date of specimen collection**	**Result** Positive, Equiv., Abnormal, Negative, Normal
Malaria	Yes	No	Pending	____ / ____ / ____	
COVID	Yes	No	Pending	____ / ____ / ____	
Influenza	Yes	No	Pending	____ / ____ / ____	
Blood culture	Yes	No	Pending	____ / ____ / ____	
CBC w/Differential	Yes	No	Pending	____ / ____ / ____	
Chemistry	Yes	No	Pending	____ / ____ / ____	
Hepatic Panel	Yes	No	Pending	____ / ____ / ____	
PT/INR	Yes	No	Pending	____ / ____ / ____	
Urine analysis	Yes	No	Pending	____ / ____ / ____	

Other testing, specify:

DETERMINE CONTACTS/ EXPOSURES:
Contact tracing should begin to determine household and other close contacts.

Name	*Full Address*	*Telephone #*	*Date of Birth*	*Relationship*
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	

Does patient live with any pets (e.g., dogs, cats, pigs)? Yes No Unk

Specify number and type of animal(s):

CASE NOTES