**New Jersey Department of Health**
**Infectious and Zoonotic Disease Program**

**MR #:**

# SUSPECT VIRAL HEMORRHAGIC FEVER INTAKE FORM

**CDRSS #:**

**Submit with all laboratory test results via encrypted email to CDSEVD.SME@doh.nj.gov or fax to 609-826-4874.**
**Questions? Call 609-826-5964.**

## DEMOGRAPHICS

| Patient Last Name | First Name | Date of Birth: | Phone number |
|---|---|---|---|
| | | | |

| Address | City | Municipality |
|---|---|---|
| | | |

| E-mail address: | Country of residence: | Occupation | Industry / work setting |
|---|---|---|---|
| | | | |

**Ethnicity**
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

**Sex**
- ☐ Male
- ☐ Female

Please identify your race (Check all that apply):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian Pacific Islander
- ☐ White
- ☐ Other

## 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 AND DIAGNOSTIC TESTING

**Viral hemorrhagic fever suspected**:

☐ Ebola ☐ Lassa fever ☐ Marburg
☐ Other:

Alternate Diagnoses:

**Is the person vaccinated for Ebola?** If yes, type and # of vaccines and when (if they don't know, have the person estimate the year, and request their immunization records)

☐ Yes ☐ No ☐ Unk

Vaccination: Date: Vaccination: Date:

**Is patient pregnant?**

☐ Yes, # of weeks _____ ☐ No ☐ Unk

| Test results | | | | | |
|---|---|---|---|---|---|
| **Name of Test** | **Performed?** | | | **Date of specimen collection** | **Result** Positive, Equiv., Abnormal, Negative, Normal |
| Malaria | ☐ Yes | ☐ No | ☐ Pending | | |
| Influenza | ☐ Yes | ☐ No | ☐ Pending | | |
| Blood culture | ☐ Yes | ☐ No | ☐ Pending | | |
| CBC | ☐ Yes | ☐ No | ☐ Pending | | |

| | | | |
|---|---|---|---|
| Chemistry | ☐Yes ☐No ☐Pending | | |
| PT/INR | ☐Yes ☐No ☐Pending | | |
| Urine analysis | ☐Yes ☐No ☐Pending | | |

Other testing, specify:

| Sign/Symptom | Response | Onset Date | Additional required information |
|---|---|---|---|
| Abdominal pain | ☐Yes ☐No ☐Unk | | Specify location of pain: |
| Anorexia | ☐Yes ☐No ☐Unk | | |
| Arthralgia | ☐Yes ☐No ☐Unk | | |
| Back pain | ☐Yes ☐No ☐Unk | | |
| Chest pain | ☐Yes ☐No ☐Unk | | |
| Chills | ☐Yes ☐No ☐Unk | | |
| Conjunctivitis | ☐Yes ☐No ☐Unk | | |
| Cough | ☐Yes ☐No ☐Unk | | |
| Diarrhea | ☐Yes ☐No ☐Unk | | |
| Encephalitis | ☐Yes ☐No ☐Unk | | Describe: |
| Fatigue | ☐Yes ☐No ☐Unk | | |
| Fever (≥100.4°F) | ☐Yes ☐No ☐Unk | | Temperature: °F |
| Headache | ☐Yes ☐No ☐Unk | | |
| Hiccups | ☐Yes ☐No ☐Unk | | |
| Loss of hearing, acute | ☐Yes ☐No ☐Unk | | |
| Myalgia | ☐Yes ☐No ☐Unk | | |
| Nausea | ☐Yes ☐No ☐Unk | | |
| Organ failure | ☐Yes ☐No ☐Unk | | Specify: |
| Rash | ☐Yes ☐No ☐Unk | | Describe: |
| Seizure | ☐Yes ☐No ☐Unk | | |
| Sepsis | ☐Yes ☐No ☐Unk | | |
| Shock | ☐Yes ☐No ☐Unk | | |
| Shortness of breath | ☐Yes ☐No ☐Unk | | |
| Sore throat | ☐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*:

**RISK FACTORS (Ask all of these questions for the 21 days preceding illness onset or diagnosis)**
*List of areas with active viral hemorrhagic fever transmission can be found at cdc.gov.*

| | |
|---|---|
| Does the patient reside in or have recent travel to a viral hemorrhagic fever endemic area or one with active<br>☐ Yes ☐ No ☐ Unk | Location:<br>Date(s):<br>Reason for travel: (select all that apply)<br>☐ Residence ☐ Business ☐ Visiting friends/relatives<br>☐ Tourism ☐ Medical/relief response<br>☐ Other: |
| Did patient have close contact with a sick person(s) who was recently in an area with active viral hemorrhagic fever transmission?<br>☐ Yes ☐ No ☐ Unk | Describe contact:<br>Date(s): |
| Did the person attend a funeral in an area with active viral hemorrhagic fever transmission?<br>☐ Yes ☐ No ☐ Unk<br>Did deceased have or may have had a viral hemorrhagic fever?<br>☐ Yes ☐ No ☐ Unk | Describe participation in funeral work:<br>Location:<br>Date(s): |
| Did the patient perform burial work in a viral hemorrhagic fever outbreak area?<br>☐ Yes ☐ No ☐ Unk<br>Did deceased have or may have had a viral hemorrhagic fever?<br>☐ Yes ☐ No ☐ Unk | Describe participation in burial work:<br>Location:<br>Date(s): |
| Did the patient have contact with semen from a man who recovered from a viral hemorrhagic fever (through oral, vaginal or anal sex)?<br>☐ Yes ☐ No ☐ Unk | Specify body fluids:<br>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 a viral hemorrhagic fever?<br>☐ Yes ☐ No ☐ Unk | Describe contact:<br>Date(s): |
| Did the patient have direct contact with objects contaminated with body fluids from a person sick with a viral hemorrhagic fever or have direct contact with the body of a person who died from a viral hemorrhagic fever?<br>☐ Yes ☐ No ☐ Unk | Describe contact:<br>Date(s): |
| Did the patient work in a laboratory where viral hemorrhagic fever specimens were handled or in a clinical laboratory in an area with active viral hemorrhagic fever transmission?<br>☐ Yes ☐ No ☐ Unk | Describe work:<br>Location:<br>Date(s): |

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|---|---|
| Was the patient a caregiver for a viral hemorrhagic fever patient or healthcare worker in an area with active viral hemorrhagic fever transmission?<br>☐Yes ☐No ☐Unk | Describe contact:<br><br>Location:<br><br>Date(s): |
| Did the patient visit a health care facility or traditional healer in a viral hemorrhagic fever outbreak area?<br>☐Yes ☐No ☐Unk | Reason for visit:<br><br>Location:<br><br>Date(s): |
| Did the patient have direct contact with fruit bats or nonhuman primates (e.g., apes, monkeys) or their feces in an area with active viral hemorrhagic fever transmission?<br>☐Yes ☐No ☐Unk | Describe contact:<br><br>Date(s): |
| Did the person consume or handle meat harvested from wild animals (bushmeat) in an area with active viral hemorrhagic fever transmission?<br>☐Yes ☐No ☐Unk | Specify meat and how it was cooked:<br><br>Location:<br><br>Date(s): |
| Did the person work or spend time in a mine or cave in an area with active viral hemorrhagic fever transmission?<br>☐Yes ☐No ☐Unk | Specify:<br><br>Location:<br><br>Date(s): |
| Did the patient have direct contact with a multimammate rat in an area with active viral hemorrhagic fever transmission?<br>☐Yes ☐No ☐Unk | Describe contact:<br><br>Date(s): |

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

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

| *Name* | *Full Address* | *Telephone #* | *Date of Birth* | *Relationship* |
|---|---|---|---|---|
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**Does patient live with any pets (e.g., dogs, cats, pigs)?** ☐Yes ☐No ☐Unk

Specify number and type of animal(s):

**CASE NOTES**