I. Purpose

The Serious Infectious Disease Screening Form is intended to (1) enhance rapid recognition of a patient who may have a communicable disease of urgent public health concern upon arrival at a health care facility and (2) prompt the rapid institution of infection control measures to minimize potential transmission to hospital staff, patients, and visitors. This screening should be conducted by the health care provider/triage nurse at intake or shortly thereafter.

II. Positive Communicable Disease Screen

A positive communicable disease triage screen is considered for any patient who meets the following criteria:

Any patient who reports any of the following epidemiologic risk factors:

a. Travel to an area that is currently experiencing or is at risk for a communicable disease outbreak of urgent public health concern (e.g., country currently experiencing an outbreak of avian influenza, or country at higher risk for re-emergence of epidemiologically significant communicable diseases); or

b. Contact with someone who is also ill and traveled to an area that is known to be or is at risk for a communicable disease outbreak of urgent public health concern; or

c. Healthcare worker with a recent exposure to a potential communicable disease of urgent public health concern; or

d. Anyone who reports being part of a cluster of two or more persons with a similar febrile, respiratory illness.

AND

Reports symptoms of fever, respiratory symptoms, vomiting, diarrhea, headache, or rash.

Patients who meet the criteria above for a positive communicable disease triage screen should be prioritized for individual placement in a private room or an Airborne Isolation Infection Room (AIIR) pending clinical evaluation. Patient, triage staff, and anyone in contact with the patient should perform hand hygiene.

III. Reporting, Testing, and Infection Control

Hospitals should follow ADPH and/or local health department notification and consultation procedures regarding known or emerging infectious diseases. With regard to infection control, hospital personnel should always follow standard patient care precautions and implement appropriate control measures as necessary. For countries at risk, consult recent health alerts from either the Centers for Disease Control and Prevention or the Alabama Department of Public Health.

1. CDC Traveler’s Health
2. Alabama Health Alert Network (HAN) Messages
3. CDC Transmission Control Precautions
4. ADPH Reportable Diseases

To report a potential serious infectious disease, call 1-800-338-8374.
IV. Patient Information

Today’s Date: ________ Time: ________ □ AM □ PM

Last Name: ________________________ First Name: ______________ Middle Name: __________

DOB: _______________ Age: _____ □ years □ months _____ Sex: □ female □ male

Race/Ethnicity: ________________________ Occupation/Avocation: ________________________

Street Address: ____________________________________________________________

City: ___________ State: _______ Zip Code: _______ County: ______________

Cell Phone: ________________________ Home Phone: ___________________________

V. Symptoms (Since traveling or contact with traveler)

Does the patient currently have or exhibit the following symptoms?

Fever (& how high if documented): □ Yes □ No □ UNK   Oral: ________ °F

Cough □ Yes □ No □ UNK   > 2 weeks _____ Bloody sputum ______

Chest pain □ Yes □ No □ UNK

Sore throat □ Yes □ No □ UNK

Difficulty swallowing □ Yes □ No □ UNK

Difficulty breathing/SOB □ Yes □ No □ UNK

Fatigue □ Yes □ No □ UNK

Muscle pain or aches □ Yes □ No □ UNK

Diarrhea □ Yes □ No □ UNK

Vomiting □ Yes □ No □ UNK

Rashes □ Yes □ No □ UNK

Open wound or lesion □ Yes □ No □ UNK

Any hemorrhagic manifestations □ Yes □ No □ UNK

Red eyes (conjunctival hemorrhage) □ Yes □ No □ UNK

Headache □ Yes □ No □ UNK

Date of symptom(s) onset: __________   General Appearance: □ Healthy □ Mildly Distressed □ Distressed

VI. Travel History:

Travel (in/to/from): __________________________________________________________

Arrival Date in US: _________________________________________________________

Travel in rural areas in above countries □ Yes □ No □ UNK

Travel in areas with known disease outbreak □ Yes □ No □ UNK

Travel in areas recently affected by natural disaster/severe weather □ Yes □ No □ UNK

Symptoms developed during travel (details)? □ Yes □ No □ UNK

While on aircraft/at airport? □ Yes □ No □ UNK

Location and symptom details: _______________________________________________
Seen for the same symptoms at another medical provider prior to being seen/admitted: ☐ Yes ☐ No ☐ UNK
Details/Location: ________________________________________________________________

VII. Exposures of Interest (in the 14 days prior to symptom onset)

Exposure to freshwater (e.g. swimming) ☐ Yes ☐ No ☐ UNK
Exposure to animal/insect bites or scratches ☐ Yes ☐ No ☐ UNK
Exposure to known ill patients ☐ Yes ☐ No ☐ UNK
Exposure to blood products or bodily fluids from known ill patient ☐ Yes ☐ No ☐ UNK
Direct contact with or care provider to anyone with known illness ☐ Yes ☐ No ☐ UNK
Exposure to livestock, dead animals, or wild animals preparation or consumption ☐ Yes ☐ No ☐ UNK
Ingestion of raw meat, “bush meat,” seafood, or unpasteurized dairy products ☐ Yes ☐ No ☐ UNK
Direct contact or participation in dead body preparation or funeral (specify) ☐ Yes ☐ No ☐ UNK
Details/Location: ________________________________________________________________

VIII. Medical Details:

Medications taken while on travel (include malaria chemoprophylaxis):

Compliance with medications: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ UNK
Pre-travel Yellow Fever vaccination: ☐ Yes ☐ No ☐ UNK
Pre-travel typhoid vaccination: ☐ Yes ☐ No ☐ UNK
Any illnesses while abroad and treatments: __________________________________________
Date of last flu vaccination: ______________________________________________________
Other pre-travel vaccinations: _____________________________________________________
Significant Past Medical History (e.g., illnesses/conditions/current antibiotic treatment) _____________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Forward this completed form, along with current lab reports and any pertinent medical history to cdfax@adph.state.al.us or fax to 334-206-3734.