Ebola Virus Disease (EVD) Consultation Record

ADPH Identifier#: AL -_____ **Today's Date:** _____
(Use the following convention: State Abbreviation + sequential numbering) **Time:** _____ ☐ AM ☐ PM

Patient Last Name:_____First Name:_____Middle Name:_____

DOB: _____ Age:_____ ☐ years ☐months Sex: ☐ female ☐male

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: _____

Citizenship: _____ Race/Ethnicity: _____

Occupation/Avocation: _____ E-mail:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

County:_____

Cell Phone: _____ Home Phone: _____

Reporting Facility Name:_____

Facility City:_____ Facility County: _____

Physician Name:_____ Phone Number: _____Ext. _____

Travel History:

Travel (in /to/ from): ☐ Guinea ☐ Liberia ☐ Sierra Leone ☐ Mali
☐ Other: _____

Travel in rural areas in above countries? ☐ Yes ☐ No ☐ Unknown

Travel in areas with known Ebola cases? ☐ Yes ☐ No ☐ Unknown

Arrival Date in US: _____

	Date	Flight #	From City/Country	To City/Country
Ground transportation:	_____		_____	_____
Flight Leg 1:	_____	_____	_____	_____
Flight Leg 2:	_____	_____	_____	_____
Flight Leg 3:	_____	_____	_____	_____
Ground transportation:	_____		_____	_____

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

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

Location and symptom details: _____

Activities in country(ies) of travel/residence:

- ☐ Medical Provider
- ☐ Care Provider for Ill Patient
- ☐ Laboratory Worker
- ☐ Administrative/Organizational
- ☐ Other (specify): _____

Seen for same symptoms at another medical provider prior to being seen at/admitted :

☐ Yes ☐ No ☐ Unknown

Details/Location: _____

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: _____

Travel medicine preparations pre-travel: _____

Significant Past Medical History (e.g., illnesses/conditions)

_____

Date of symptom onset: _____

Typical symptoms:

Fever (& how high if documented):	☐ Yes	☐ No	☐ UNK	Oral: _____ °F
Intense weakness	☐ Yes	☐ No	☐ UNK	
Muscle pain	☐ Yes	☐ No	☐ UNK	
Headache	☐ Yes	☐ No	☐ UNK	
Sore throat	☐ Yes	☐ No	☐ UNK	
Vomiting	☐ Yes	☐ No	☐ UNK	
Diarrhea	☐ Yes	☐ No	☐ UNK	
Any hemorrhagic manifestations (specify)	☐ Yes	☐ No	☐ UNK	_____

Other symptoms:

Rashes	☐ Yes	☐ No	☐ UNK
Red eyes (conjunctival hemorrhage)	☐ Yes	☐ No	☐ UNK
Hiccups	☐ Yes	☐ No	☐ UNK
Cough	☐ Yes	☐ No	☐ UNK
Chest pain	☐ Yes	☐ No	☐ UNK
Difficulty breathing/SOB	☐ Yes	☐ No	☐ UNK
Difficulty swallowing	☐ Yes	☐ No	☐ UNK

BP: _____ Pulse: _____ Respirations: _____

General Appearance: ☐ Healthy ☐ Mildly ☐ Distressed ☐ Toxic

Labs Platelet count: _____

AST/ALT: _____

INR: _____

Creatinine: _____

Hgb/Hct: _____

Radiographic testing (if any):

Thick/thin smear for malaria: ☐ Yes ☐ No ☐ UNK Result: _____

Rapid test for malaria (type if known): ☐ Yes ☐ No ☐ UNK Result: _____

Exposures of Interest: (In the 21 days prior to symptom onset)

Exposure to known Ebola patients? ☐ Yes ☐ No ☐ UNK

Direct contact with known Ebola patients without PPE? ☐ Yes ☐ No ☐ UNK

Exposure to blood products or bodily fluids from known Ebola patients? ☐ Yes ☐ No ☐ UNK

Exposure to hospital settings known for treating Ebola patients: ☐ Yes ☐ No ☐ UNK

Exposure to dead animals/"Bushmeat" preparation or consumption (details): ☐ Yes ☐ No ☐ UNK

Details: _____

Visitation of caves inhabited by bats in country of concern: ☐ Yes ☐ No ☐ UNK

Care provider to anyone in [from] affected area: ☐ Yes ☐ No ☐ UNK

Participation in dead body preparation or funeral (specify details): ☐ Yes ☐ No ☐ UNK

Details: _____

Infection Control

Conveyance used to bring patient to hospital/clinic: ☐ POV ☐Ambulance ☐ Medevac Aircraft ☐ Other: _____

Current location of patient: _____

To be admitted: ☐ Yes ☐ No ☐ Already admitted to:

Facility name: _____

Ward/Room: _____

Name, date, and type (e.g., outpatient clinic, emergency room) of facilities visited while symptomatic with this illness: _____

Infection control procedures in place (check all that apply): ☐ Contact ☐ Droplet ☐ Airborne ☐ Standard

Above procedures put in place when?

☐ Upon Arrival ☐ After ___Hours ____ Days ☐ Not done ☐ Other: _____

Personal Protective Equipment required for entering patient's room (check all that apply):

☐ Eye Protection ☐ Facemask ☐ Goggles ☐ Gowns ☐ Gloves

☐ Other, please list: _____

Have any aerosol generating procedures (e.g. bronchoscopy, sputum induction, CPE, intubation and extubations, open airway suctioning, etc.) been performed on the patient? ☐ Yes ☐ No ☐ UNK

Describe if yes: _____

Have any personnel had unprotected exposures (e.g. recommended PPE not worn, percutaneous or mucous membrane exposure) to the patient (elaborate)? ☐ Yes ☐ No ☐ UNK

Describe if yes: _____

Were laboratory workers using CDC recommended precautions? ☐ Yes ☐ No ☐ UNK

Describe if yes: _____

Reporting

Case discussed with State: ☐ Yes ☐ No

Comments: _____

Submitted by: Last Name _____First Name _____MI ___

Title: _____

For additional reference if additional laboratory testing considered:
http://www.cdc.gov/ncezid/dhcpp/vspb/specimens.html