Ebola or Marburg case investigation and recording sheet

Case ID number: ________________________

Date of case detection ___/___/___

Case reported by *(tick the box and specify)*:

☐ Mobile team, n° _____________ ☐ Health centre _________________________

☐ Hospital __________________ ☐ Other: _________________________

Form filled in by (last and first name) ____

Information passed on by (last and first name) ____

Relationship with the patient ____

Patient identity Nickname: _________________________

Surname ___________________ Second Names ______________ First Names ________________

Son/daughter of (name of father/mother) ____

Date of birth ___/___/___ age (years)_____ Sex ☐ M ☐ F

Ordinary residence: Head of household (last and first name) _____________________________

Village/neighbourhood of residence ______________ District ___________

GPS coordinates of domicile: Latitude _____________________ Longitude ____________________

Nationality: ____________________________ Ethnic group: ____________________________

Patient's profession *(tick the appropriate box and provide details if necessary)*

☐ Planter ☐ Homemaker ☐ Child ☐ Hunter/Bushmeat etailer

☐ Health-care worker, specify: health-care facility ________________ Qualification _____________

☐ Mineworker/Gold prospector _______________ Starting date of mining activity: _________________

☐ Pupil/Student ☐ Other (specify) ______________________

Patient's condition

Condition of the patient when found ☐ Alive ☐ Dead

If deceased, date of death ___/___/___

Place of death: ☐ Community, village/neighbourhood __________________ District _____________

☐ Hospital, name and department ______________________ District _____________

Burial place, name of village/neighbourhood __________________________ District _____________

History of present illness

Date on onset of symptoms ___/___/___

Name of the village where the patient became ill ____________________ District _______________

Has the patient moved around since he/she became ill? ☐ Yes ☐ No ☐ DK

If the answer is "yes", complete the list indicating villages, health-care facilities, and districts:

Village _________________ Health-care facility___________________ District ______________

Village _________________ Health-care facility___________________ District ______________

Village _________________ Health-care facility___________________ District ______________

Clinical

Does the patient show any of the following symptoms *(tick all applicable)*

Has the patient had a fever? ☐ Yes ☐ No ☐ DK

If so, date of fever onset: ___/___/___

Does the patient have or had any of the following symptoms *(tick the corresponding boxes and provide details if necessary)*:

- headaches ☐ Yes ☐ No ☐ DK

- diarrhoea ☐ Yes ☐ No ☐ DK
- stomach pain ☐ Yes ☐ No ☐ DK
- vomiting ☐ Yes ☐ No ☐ DK
- lethargy ☐ Yes ☐ No ☐ DK
- anorexia ☐ Yes ☐ No ☐ DK
- muscular pain ☐ Yes ☐ No ☐ DK
- difficulty swallowing ☐ Yes ☐ No ☐ DK
- difficulty breathing ☐ Yes ☐ No ☐ DK
- intense coughing ☐ Yes ☐ No ☐ DK
- skin rash ☐ Yes ☐ No ☐ DK
- bleeding at injection points ☐ Yes ☐ No ☐ DK
- bleeding gums (Gingivitis) ☐ Yes ☐ No ☐ DK
- bleeding in eye (conjunctival injection) ☐ Yes ☐ No ☐ DK
- dark or bloody stool (melaena) ☐ Yes ☐ No ☐ DK
- vomiting of blood (haematemesis) ☐ Yes ☐ No ☐ DK
- nose bleed (epistaxis) ☐ Yes ☐ No ☐ DK
- vaginal bleeding outside of menstruation ☐ Yes ☐ No ☐ DK

Exposure risk

- Has the patient been in contact with a **suspected or confirmed case** in the 3 weeks preceding the onset of the symptoms? ☐ Yes ☐ No ☐ DK

If so, specify: Last name ______________________________ First name ________________________

At the time of contact, was the suspected case ☐ alive or ☐ dead? If dead, date of death ___/___/___

Date of last contact with the case ___/___/___

- Was the patient **hospitalized** or has he/she visited a hospital nearby in the 3 weeks preceding the onset of the symptoms? ☐ Yes ☐ No ☐ DK

If so, where ______________________________ when (dates) ___/___/___ - ___/___/___

- Has the patient seen a **traditional healer** in the 3 weeks preceding the onset of the symptoms? ☐ Yes ☐ No ☐ DK

If so, last name:______________________________ Village ___________________ District _______________

Where and when did the consultation take place? Place ______________________ Date: ___/___/___

Has the patient received traditional treatment? ☐ Yes ☐ No ☐ DK

If so, specify the type of traditional treatment: _______________________________________

- Has the patient attended any **funerals** in the 3 weeks preceding the onset of the symptoms? ☐ Yes ☐ No ☐ DK

If so, last and first name of the deceased: ____

- Has the patient had contact with any wild **animals** in the 3 weeks preceding the onset of the symptoms? ☐ Yes ☐ No ☐ DK

If so, kind of animal _____________________ Locality ___________________ Date ___/___/___

- Has the patient worked or spent time in a **mine/cave inhabited by bat colonies** in the 3 weeks preceding the onset of the symptoms?

☐ Yes ☐ No ☐ DK

If so, name of the mine____________________ Locality ___________________ Date ___/___/___

- Has the patient **travelled** in the 3 weeks preceding the onset of the symptoms?

☐ Yes ☐ No ☐ DK

If so, where to ________________________ and when ___/___/___ to ___/___/___

Specimen collection

Question for the investigation team: after having provided clear and full information to the patient (or in absentia to his/her family or legal guardian) did you obtain his/her express and/or informed consent to the collection of specimens?

☐ Yes ☐ No ☐ DK

- Did you collect specimens? ☐ Yes ☐ No ☐ DK

If so, when ___/___/___ Type of specimen? ☐ Blood ☐ Urine ☐ Saliva ☐ Biopsy ☐ Stool

Transfer of the patient to hospital

To be completed ONLY by mobile teams and health centres

Was the patient taken to hospital? ☐ Yes ☐ No

If so, name of hospital ________________________ Date of transport ___/___/___

Updated information provided from the isolation unit

To be completed ONLY by the hospital OR the surveillance office

Was the patient referred to an isolation area? ☐ Yes ☐ No

If so, name of hospital ________________________ Date of hospitalization ___/___/___

Family member(s) accompanying the patient, last and first name ________________________

Date of discharge ___/___/___ OR Date of death ___/___/___

Laboratory data

The specimen tested was collected from: ☐ Sick person ☐ Recovering patient ☐ Post-mortem

Date taken ___/___/___ Date result received ___/___/___ Lab ID ______________

Type of specimen ☐ Blood sample using dry tube ☐ Blood using anticoagulants

☐ Saliva ☐ Stool / Urine

☐ Biopsy ☐ Other, specify ______________

Results						
	Antigen detected	☐ pos	☐ neg	☐ NA	Date	___/___/___
	IgM serology	☐ pos	☐ neg	☐ NA	Date	___/___/___
	IgG serology	☐ pos	☐ neg	☐ NA	Date	___/___/___
	RT-PCR	☐ pos	☐ neg	☐ NA	Date	___/___/___
	Virus culture	☐ pos	☐ neg	☐ NA	Date	___/___/___
	Immunohistochemical staining	☐ pos	☐ neg	☐ NA	Date	___/___/___
	Immunofluorescence	☐ pos	☐ neg	☐ NA	Date	___/___/___

Outcome (to be verified 4 weeks after onset of symptoms)

☐ alive ☐ dead

in case of death, date ___/___/___

Final case classification *(tick the appropriate box)*

☐ Suspected **☐ Probable** **☐ Confirmed** **☐ Non-case**