Contact ID # _____ Interview Date: _____

EMERGENCY DEPARTMENT OR FLIGHT CONTACT TO EBOLA PATIENT INTERVIEW FORM

SECTION I: GENERAL INFORMATION

Interviewer Information

Interviewer Name (Last, First): _____

State/Local Health Department: _____

Phone number: _____ Email address: _____

Ebola Patient Information (Patient Associated with Contact)

Ebola Patient CalREDIE ID # _____

Last Name: _____ First Name: _____

DOB: MM / DD / YYYY

Date of illness onset: MM / DD / YYYY

Date of hospital admission: MM / DD / YYYY

Name of admitting hospital: _____

Date patient was isolated in a healthcare facility: MM / DD / YYYY

At the time of this report, is the patient? ☐ Confirmed ☐ Probable ☐ Unknown

Notes:

Contact Setting

☐ Emergency Department/Other Outpatient Healthcare Setting ☐ Flight

If emergency department/other healthcare setting please provide the information below:

Name of healthcare facility: _____

Dates/times Ebola case was in the emergency department/waiting room:

Arrived: MM / DD / YYYY _____ ☐ AM ☐ PM Departed: MM / DD / YYYY _____ ☐ AM ☐ PM

Dates/times contact was in the emergency department/waiting room:

Arrived: MM / DD / YYYY _____ ☐ AM ☐ PM Departed: MM / DD / YYYY _____ ☐ AM ☐ PM

Contact ID # _____ Interview Date: _____

Contact Setting (Continued)

If flight, please provide the below information:

Name of Airline: _____

Flight Number: _____

Seat assignment of Ebola case: _____

Class of travel of Ebola case: ☐ First/Business ☐ Economy

Seat assignment of contact: _____

Class of travel of contact: ☐ First/Business ☐ Economy

Contact Information

Last Name: _____ First Name: _____

Date of birth: MM / DD / YYYY Age: _____

Sex: ☐ Male ☐ Female

If female, are you currently pregnant? ☐ Yes ☐ No

If yes, what is you EDD: MM / DD / YYYY

Home address: (add all places where the contact resides including temporary residence due to travel)

Street Address #1: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Phone number: _____ Email address: _____

Alternate phone number/email: _____

Is this the current residence: ☐ Yes ☐ No

Is this the permanent residence: ☐ Yes ☐ No

Is this a congregate setting (dorm, assisted living, etc.): ☐ Yes ☐ No

How many people live at this address: _____

Contact ID # _____ Interview Date: _____

Contact Information (Continued)

Street Address #2: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Country: _____

Is this the current residence: ☐ Yes ☐ No

Is this the permanent residence: ☐ Yes ☐ No

Is this a congregate setting (dorm, assisted living, etc.): ☐ Yes ☐ No

How many people live at this address: _____

Notes regarding address section:

_____

_____

_____

_____

_____

_____

(Add additional addresses and contact information on the back of the form)

Who is providing information for this contact?

☐ Contact (Self)

☐ Other, specify person (Last, First): _____

Relationship to contact: _____

Reason contact unable to provide information: ☐ Contact is a minor ☐ Other _____

Contact primary language: _____

Was this form administered via a translator? ☐ Yes ☐ No

Contact ID # _____ Interview Date: _____

Symptoms

Do you currently have any of the following symptoms?

Symptom	Date of onset
☐ No symptoms	
☐ Temperature ≥99.6° F (oral)	_____
☐ Chills	_____
☐ Weakness	_____
☐ Headache	_____
☐ Muscle Aches	_____
☐ Abdominal Pain	_____
☐ Diarrhea ____times/day	_____
☐ Vomiting	_____
☐ Unexplained hemorrhage	_____
☐ Other _____	_____

Do you belong to a health network? ☐ Yes ☐ No Name of health network: _____

Occupation

What is your occupation? _____

What is your occupation setting? _____

Place of work and address:

_____

_____

Contact ID # _____

Interview Date: _____

Medical History

Do you routinely undergo any routine medical procedures or monitoring (i.e., glucose monitoring, dialysis, injections)?

☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

(If possible contact who undergo routine medical procedures or monitoring are determined to be exposed, additional recommendations may be needed to accommodate routine medical care safely)

Travel Plans

Do you have any upcoming travel plans?

☐ Yes ☐ No ☐ Unknown ☐ Refused

If yes, please describe where, when, and how you are planning to travel (please include airlines and flight numbers or other relevant and comparable commercial transportation information):

_____

_____

_____

_____

_____

_____

_____

_____

Contact ID # _____

Interview Date: _____

SECTION II: EXPOSURE ASSESSMENT

For Health Department Use ONLY

1. Was the Ebola case experiencing any Ebola symptoms while in the emergency department/on the flight?

   ☐ Yes ☐ No ☐ Unknown

2. Was the Ebola case experiencing vomiting or diarrhea while in the emergency department/on the flight?

   ☐ Yes ☐ No ☐ Unknown

3. Was the Ebola case experiencing bleeding/hemorrhaging while in the emergency department/on the flight?

   ☐ Yes ☐ No ☐ Unknown

If YES to question 1 and no to both questions 2 and 3, then the contact is considered to have “Low (but not zero) risk” exposure, please skip to SECTION III: SUMMARY.

If YES or UNKNOWN either question 2 or 3 above, please ask the below questions to further assess the potential risk of the contact.

Questions for Contact

1. Did you use the bathroom while you were in the emergency department/on the flight?

   ☐ Yes ☐ No ☐ Unknown ☐ Refused

   If FLIGHT and YES,

   a. Which bathrooms on the aircraft did you use?

      ☐ First/business class only ☐ Economy class only

      ☐ Both, first/business class and economy class

2. Did someone vomit or have diarrhea in the same room/cabin as you while you were in the emergency room/on the flight?

   ☐ Yes ☐ No ☐ Unknown ☐ Refused

Questions for Contact (Continued)

If YES,

a. Do you know the name of this person?

☐ Yes – Name: _____ ☐ No

b. Did any of the vomit or diarrhea get on you?

☐ Yes ☐ No ☐ Unknown ☐ Refused

c. Approximately how far away from the person who vomited or had diarrhea were you?

_____ ☐ Feet ☐ Meters

3. Did you get blood from someone other than yourself on you while in the emergency department/on the flight?

☐ Yes ☐ No ☐ Unknown ☐ Refused

If YES,

a. Do you know the name of the person whose blood got on you?

☐ Yes – Name: _____ ☐ No

SECTION III: SUMMARY

Exposure Category

☐ HIGH RISK (quarantine, twice daily direct active monitoring)

☐ SOME RISK (movement restrictions, twice daily direct active monitoring)

☐ LOW (BUT NOT ZERO) RISK (twice daily direct active monitoring for travelers on an aircraft with, and sitting within 3 feet of, a person with Ebola; all others twice daily active monitoring)

☐ NO RISK EXPOSURES IDENTIFIED (self-monitoring)

LAST DATE OF EXPOSURE: _____

Contact ID # _____

Interview Date: _____

Follow-up Actions

Adhere to recommendations found in 'CDPH Guidance for the Evaluation and Management of Contacts to Ebola Virus'.

☐ No further follow-up, self-monitoring recommended

Why is no follow-up needed?

☐ No risk exposures identified

☐ Last exposure was > 21 days ago

☐ Other _____

Last date of self-monitoring: _____

☐ Twice daily active monitoring recommended

Last date of follow-up: _____

☐ Twice daily direct active monitoring recommended

Last date of follow-up: _____

☐ Quarantine recommended

Last date of quarantine: _____

☐ Work exclusion recommended

Last date of work exclusion: _____