State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

Local ID Number _____

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)

☐ Preliminary ☐ Final

VIRAL HEMORRHAGIC FEVER (ANIMAL) CASE REPORT

Check one: ☐ Ebola ☐ Reston
☐ Lassa ☐ Other: _____
☐ Marburg

Please securely email the completed form to IDB-SSS@cdph.ca.gov; otherwise, mail the completed form to IDB-SSS at the address above.

PATIENT INFORMATION

Name	*Age*	☐ Years ☐ Months ☐ Days	*Species*
ID Number / License Tag	*Sex* ☐ Male ☐ Female	*Reproductive Status*	*Breed*
Address Number & Street - Residence	*Apartment / Unit Number*		*Color(s)*
City / Town	*State*	*Zip Code*	*Markings*
Census Tract	*County of Residence*	*Medical Record Number*	

Type of Residence

☐ Private Home ☐ Laboratory ☐ Zoologic Park, Refuge, Sanctuary
☐ Commercial Business ☐ Other: _____

OWNER / CARETAKER INFORMATION

Owner / Caretaker Name		
Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*
E-mail Address	*Other Electronic Contact Information*	

Fill out owner / caretaker address only if it differs from patient address listed above.

Address Number & Street - Residence	*Apartment / Unit Number*	
City / Town	*State*	*Zip Code*
Census Tract	*County of Residence*	

VETERINARY INFORMATION

Veterinarian Name - Last Name	*First Name*	*Telephone Number*

First three letters of owner's / caretaker's last name: | | | |

CLINICAL FINDINGS

Onset Date (mm/dd/yyyy)

Signs	Yes	No	Unk	Signs	Yes	No	Unk
Fever *If Yes, highest temperature (specify °F/°C):*_____				Hepatosplenomegaly			
Lethargy				Bleeding not related to injury *If Yes, type of bleeding* ☐ Nose bleed ☐ Black or bloody stool ☐ Vomiting blood ☐ Hemorrhagic or purpuric rash ☐ Coughing up blood ☐ Petechiae or ecchymosis ☐ Rectal bleeding ☐ Other: _____			
Maculopapular rash							
Lameness							
Anorexia				*Other signs / symptoms (specify)*			
Vomiting							
Diarrhea							

VETERINARY CARE

Date of First Veterinary Examination (mm/dd/yyyy)	*Was patient hospitalized?* ☐ Yes ☐ No ☐ Unknown	*Was patient placed in isolation?* ☐ Yes ☐ No ☐ Unknown

Specify details below for this patient's veterinary care.

Clinic / Hospital Name 1	*Street Address*			*Admission Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
Veterinarian Name 1	*State*	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*
Clinic / Hospital Name 2	*Street Address*			*Admission Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
Veterinarian Name 2	*State*	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*

OUTCOME

☐ Survived, as of _____ (mm/dd/yyyy)

☐ Died, on _____ (mm/dd/yyyy)

☐ Euthanized, on _____ (mm/dd/yyyy)

☐ Unknown

First three letters of owner's / caretaker's last name: | | | |

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY - TESTS ***(Please submit copies of all lab reports, including CBCs, associated with this illness.)***

Type of Virus Detected ☐ Ebola ☐ Lassa ☐ Marburg ☐ Reston	*Laboratory Name*	*Telephone Number*

Virus Detection Test(s)	Results				
	Specimen Type (specify)	Date Collected	Positive	Negative	Inconclusive
Virus isolation					
Polymerase chain reaction (PCR)					
Immunohistochemistry					
Electron microscopy					
Other (specify): _____					

Serology (ELISA)

Test ☐ Antigen-capture ☐ IgM specific ☐ IgG specific	*Date Collected (mm/dd/yyyy)*	*Result* ☐ Positive ☐ Negative ☐ Inconclusive
	Specimen Type (specify) ☐ Serum ☐ Blood ☐ CSF ☐ Other: _____	*Measurements* Titer: _____ Optical density: _____

LABORATORY RESULTS SUMMARY - TESTS ***(continued)***

Type of Virus Detected ☐ Ebola ☐ Lassa ☐ Marburg ☐ Reston	*Laboratory Name*	*Telephone Number*

Virus Detection Test(s)	Results				
	Specimen Type (specify)	Date Collected	Positive	Negative	Inconclusive
Virus isolation					
Polymerase chain reaction (PCR)					
Immunohistochemistry					
Electron microscopy					

Serology (ELISA)

Test ☐ Antigen-capture ☐ IgM specific ☐ IgG specific	*Date Collected (mm/dd/yyyy)*	*Result* ☐ Positive ☐ Negative ☐ Inconclusive
	Specimen Type (specify) ☐ Serum ☐ Blood ☐ CSF ☐ Other: _____	*Measurements* Titer: _____ Optical density: _____

First three letters of owner's / caretaker's last name: | | | |

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 2 TO 21 DAYS PRIOR TO ONSET OF ILLNESS

TRAVEL HISTORY

*Was the patient **outside of county of residence** during the incubation period?*	*Did the patient originate from **outside the U.S.** during the incubation period?*
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

If Yes for either of these questions, specify all locations and dates below.

TRAVEL ITINERARY DURING INCUBATION PERIOD

Location (city, county, state, country)	Date / Location - Origination	Date / Location - Arrival

EXPOSURE / RISK FACTORS

DID THE PATIENT EXPERIENCE ANY OF THE FOLLOWING EXPOSURES DURING THE INCUBATION PERIOD?

Exposure	Yes	No	Unk	If Yes, Provide Additional Details or Specify as Noted	
Contact with an ill or deceased person				*Exposure Type* ☐ Blood ☐ Respiratory secretions ☐ Urine/feces ☐ Other (specify): _____	*Date of Last Contact (mm/dd/yyyy)*
Contact with an ill non-human primate (e.g. monkey, chimpanzee, etc.)				*Exposure Type* ☐ Blood ☐ Respiratory secretions ☐ Urine/feces ☐ Other (specify): _____	*Date of Last Contact (mm/dd/yyyy)*
Contact with a person who lived in or visited a foreign country within 6 weeks				*Exposure Type* ☐ Blood ☐ Respiratory secretions ☐ Urine/feces ☐ Other (specify): _____	*Date of Last Contact (mm/dd/yyyy)*
Contact with blood or body fluids of a confirmed VHF case-patient 0-3 weeks after the confirmed case-patient's onset of illness				*Exposure Type* ☐ Blood ☐ Respiratory secretions ☐ Urine/feces ☐ Other (specify): _____	*Date of Last Contact (mm/dd/yyyy)*
Contact with blood or body fluids of a confirmed VHF case-patient 3-10 weeks after the confirmed case patient's onset of illness				*Exposure Type* ☐ Blood ☐ Respiratory secretions ☐ Urine/feces ☐ Other (specify): _____	*Date of Last Contact (mm/dd/yyyy)*

In what country did exposure likely occur?

First three letters of owner's / caretaker's last name: | | | |

CONTACTS / OTHER ILL PERSONS

Did any persons or animals have contact with the patient's blood or body fluids during the first 3 weeks after onset of illness? ☐ Yes ☐ No ☐ Unknown	If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number	Relationship to Patient	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	
	City	State	Zip Code		
Name 2	Age	Gender	Telephone Number	Relationship to Patient	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	
	City	State	Zip Code		

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
First Reported By ☐ Clinician ☐ Laboratory ☐ Other (specify):_____		Health education provided? ☐ Yes ☐ No ☐ Unknown	Restriction / clearance needed? ☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unknown	Contact Name / Case Number

DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 6)
☐ Confirmed ☐ Not a case ☐ Undetermined

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unk	If Yes, extent of outbreak: ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unk ☐ Other (specify):_____

STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Not a case ☐ Undetermined ☐ Need additional information

First three letters of owner's / caretaker's last name: | | | |

CASE DEFINITION

VIRAL HEMORRHAGIC FEVER (ANIMAL) (2011)

SUBTYPE(S)

- Ebola virus
- Lassa virus
- Marburg virus
- Reston virus

LABORATORY CRITERIA FOR DIAGNOSIS

One or more of the following laboratory findings:

- Detection of viral hemorrhagic fever (VHF) viral antigens in blood by Enzyme-Linked Immunosorbent Assay (ELISA) antigen detection
- VHF viral isolation in cell culture for blood or tissues
- Detection of VHF-specific genetic sequence by Reverse Transcription-Polymerase Chain Reaction (RT-PCR) from blood or tissues
- Detection of VHF viral antigens in tissues by immunohistochemistry

EPIDEMIOLOGIC LINKAGE

One or more of the following exposures within the 3 weeks before onset of symptoms:

- Contact with blood or other body fluids of a patient with VHF
- Residence in—or travel to—a VHF endemic area
- Housed in a laboratory that handles VHF specimens
- Housed in a laboratory that handles bats, rodents, or primates from endemic areas

CASE CLASSIFICATION

Confirmed: Case meets the laboratory criteria.

COMMENTS

VHF refers to viral hemorrhagic fever caused by Old World filoviruses: Ebola, Lassa, Marburg, or Reston virus.