Contact ID # ____________________ Interview Date: ____________

HOUSEHOLD OR OTHER COMMUNITY 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 ID # ____________________

Interview Date: ____________

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 your 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: ______

Street Address #2: ____ Apt. # ______________

City: ___________________________ County: ___________________ State: __________ Zip: ________________

Country: ___________________________

Is this the current residence: ☐ Yes ☐ No

Is this the permanent residence: ☐ Yes ☐ No

Contact ID # ____________________

Interview Date: ____________

Contact Information (Continued)

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

Symptoms

Do you currently have any of the following symptoms?

Symptom	Date of onset
☐ No symptoms	
☐ Temperature $\geq$99.6° F (oral)	MM / DD / YYYY
☐ Chills	MM / DD / YYYY
☐ Weakness	MM / DD / YYYY
☐ Headache	MM / DD / YYYY
☐ Muscle Aches	MM / DD / YYYY
☐ Abdominal Pain	MM / DD / YYYY
☐ Diarrhea ____times/day	MM / DD / YYYY
☐ Vomiting	MM / DD / YYYY
☐ Unexplained hemorrhage	MM / DD / YYYY

If yes, location: ________________________________

☐ Other ________________ MM / DD / YYYY

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

Occupation

What is your occupation? ____

What is your occupation setting? ____

Occupation (Continued)

Place of work and address:

____

____

____

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)

SECTION II: EXPOSURE ASSESSMENT

Exposure History

1. What is your relationship to the patient?

   ☐ Partner/spouse ☐ Family member ☐ Co-worker ☐ Friend/acquaintance

   ☐ Classmate ☐ Neighbor/community member ☐ Other: _________________________

2. Did you reside in the same house as the patient while the patient was ill (include dates)?

   ☐ Yes ☐ No

Exposure History (Continued)

If yes, date of last encounter: MM / DD / YYYY

3. Did you spend time in the patient's household while the patient was ill (include dates])?

☐ Yes ☐ No

If yes, date of last encounter: MM / DD / YYYY

4. Were you within 6 feet of (name of person) in a location outside (name of person)'s home, for example – at work, at a religious institution, in school, at a social gathering, at a restaurant, park or anywhere else while the patient was ill (include dates)?

☐ Yes ☐ No

If yes, date of last encounter: MM / DD / YYYY

4a. If yes, did that contact take place in (check all that apply):

☐ Workplace

☐ Day care, school or university

☐ Religious organization

☐ Social or family gathering

☐ Restaurant

☐ Park

☐ Emergency Department or other healthcare setting

☐ Plane

☐ Public transportation (e.g., bus, train)

☐ Other household (not patient's)

☐ Shared same vehicle (personal vehicle, taxi; specify type of vehicle, provide details in question 4)

☐ Other (specify): ____

Exposure History (Continued)

5. Did you have any other contact with the patient while he/she was ill that is not captured above?

☐ Yes ☐ No ☐ Unsure

If yes, please describe and provide dates of first and last contact:

____

____

____

____

If the contact answers No to questions 1 - 5 the contact has no exposure. Skip to Section III: Summary.

If the contact answers Yes to any question, complete the activities table below.

6. Provide the name of the place(s), the address(es), the date(s) and other information about the location where contact occurred (e.g., household, workplace, school, etc.).

Name of Place or Type of Vehicle	Address (if applicable)	Date(s)	Time spent within 6 feet of the patient	Other information on activity

Activities During Exposure Period

During the patient's infectious period from MM / DD / YYYY to MM / DD / YYYY (date the patient was isolated) did you:

Exposed – HIGH RISK		
Type of Exposure	**Dates of Exposure**	**Additional Details/Describe**
Take care of the patient while they were sick? ☐ Yes ☐ No		
Touch the patient's blood, stool, saliva, urine, vomit or other body fluids? ☐ Yes ☐ No		
Clean up spills of urine, stool, blood, saliva or other body fluids of the patient without appropriate PPE or training? ☐ Yes ☐ No		
Have sex with the patient? ☐ Yes ☐ No		
Kiss the patient? ☐ Yes ☐ No		
Touch the patient? ☐ Yes ☐ No		
Get stuck with any sharp object that had the patient's blood or body fluids on it? ☐ Yes ☐ No		
Share any personal hygiene equipment with the patient (toothbrush, razor)? ☐ Yes ☐ No		

Contact ID # ____________________ Interview Date: ____________

Activities During Exposure Period (Continued)

Exposed – HIGH RISK		
Type of Exposure	**Dates of Exposure**	**Additional Details/Describe**
Sleep or lie in the same bed as the patient? ☐ Yes ☐ No		
Help wash or bathe the patient? ☐ Yes ☐ No		
Do the laundry of the patient? ☐ Yes ☐ No		
Touch the bedding or clothing or other objects that had not been decontaminated? ☐ Yes ☐ No		
Share food with the patient? ☐ Yes ☐ No		
Eat off the same plate as the patient? ☐ Yes ☐ No		
Share drinks or cigarettes with the patient? ☐ Yes ☐ No		

Contact ID # ____________________ Interview Date: ____________

Activities During Exposure Period (Continued)

Exposed – SOME RISK		
Type of Exposure	**Dates of Exposure**	**Additional Details/Describe**
Use the same bathroom as the patient while the patient was experiencing vomiting, diarrhea, or hemorrhage? ☐ Yes ☐ No		
Spend a prolonged amount of time (>1 hour) within 6 feet of the patient while the patient was NOT experiencing diarrhea, vomiting, or hemorrhage? ☐ Yes ☐ No		
Uncertain Exposure – LOW (BUT NOT ZERO) RISK		
Type of Exposure	**Dates of Exposure**	**Additional Details/Describe**
Clean up spills of urine, vomit, stool, blood, saliva or other body fluids of the patient with appropriate PPE and training? ☐ Yes ☐ No		

SECTION III: SUMMARY

Exposure Category

☐ HIGH RISK CONTACT (quarantine, direct active monitoring)

☐ SOME RISK CONTACT (movement restrictions, direct active monitoring)

☐ LOW (BUT NOT ZERO) RISK CONTACT (direct active monitoring for U.S. based healthcare workers caring for symptomatic Ebola patients while wearing appropriate PPE, active monitoring for all others)

☐ 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: ____________________________