CHAPTER 7 - ANNEXES

Annex 5. 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**