

- 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

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	<input type="checkbox"/> pos	<input type="checkbox"/> neg	<input type="checkbox"/> NA	Date	___/___/___
	IgM serology	<input type="checkbox"/> pos	<input type="checkbox"/> neg	<input type="checkbox"/> NA	Date	___/___/___
	IgG serology	<input type="checkbox"/> pos	<input type="checkbox"/> neg	<input type="checkbox"/> NA	Date	___/___/___
	RT-PCR	<input type="checkbox"/> pos	<input type="checkbox"/> neg	<input type="checkbox"/> NA	Date	___/___/___
	Virus culture	<input type="checkbox"/> pos	<input type="checkbox"/> neg	<input type="checkbox"/> NA	Date	___/___/___
	Immunohistochemical staining	<input type="checkbox"/> pos	<input type="checkbox"/> neg	<input type="checkbox"/> NA	Date	___/___/___
	Immunofluorescence	<input type="checkbox"/> pos	<input type="checkbox"/> neg	<input type="checkbox"/> 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