Annex 5. Ebola or Marburg case investigation and recording sheet

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
CHAPTER 7 - ANNEXES

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?*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>DK</th>
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- Did you collect specimens?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>DK</th>
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If so, when ___/___/___  

<table>
<thead>
<tr>
<th>Type of specimen?</th>
<th>Blood</th>
<th>Urine</th>
<th>Saliva</th>
<th>Biopsy</th>
<th>Stool</th>
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**Transfer of the patient to hospital**

*To be completed ONLY by mobile teams and health centres*

Was the patient taken to hospital?  

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>DK</th>
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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?  

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<th>Yes</th>
<th>No</th>
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If so, name of hospital __________________________ Date of hospitalization ___/___/___

Family member(s) accompanying the patient, last and first name __________________________

<table>
<thead>
<tr>
<th>Date of discharge</th>
<th><em><strong>/</strong></em>/___</th>
<th>OR</th>
<th>Date of death</th>
<th><em><strong>/</strong></em>/___</th>
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**Laboratory data**

The specimen tested was collected from:  

- Sick person  
- Recovering patient  
- Post-mortem

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<thead>
<tr>
<th>Date taken</th>
<th><em><strong>/</strong></em>/___</th>
<th>Date result received</th>
<th><em><strong>/</strong></em>/___</th>
<th>Lab ID</th>
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<table>
<thead>
<tr>
<th>Type of specimen</th>
<th>Blood sample using dry tube</th>
<th>Blood using anticoagulants</th>
<th>Saliva</th>
<th>Stool / Urine</th>
<th>Biopsy</th>
<th>Other, specify</th>
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<thead>
<tr>
<th>Results</th>
<th>Antigen detected</th>
<th>pos</th>
<th>neg</th>
<th>NA</th>
<th>Date</th>
<th><em><strong>/</strong></em>/___</th>
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<tbody>
<tr>
<td>IgM serology</td>
<td>pos</td>
<td>neg</td>
<td>NA</td>
<td>Date</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>IgG serology</td>
<td>pos</td>
<td>neg</td>
<td>NA</td>
<td>Date</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>RT-PCR</td>
<td>pos</td>
<td>neg</td>
<td>NA</td>
<td>Date</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
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<tr>
<td>Virus culture</td>
<td>pos</td>
<td>neg</td>
<td>NA</td>
<td>Date</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Immunohistochemical staining</td>
<td>pos</td>
<td>neg</td>
<td>NA</td>
<td>Date</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Immunofluorescence</td>
<td>pos</td>
<td>neg</td>
<td>NA</td>
<td>Date</td>
<td><em><strong>/</strong></em>/___</td>
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**Outcome** (to be verified 4 weeks after onset of symptoms)

- alive  
- dead

In case of death, date ___/___/___

**Final case classification** *(tick the appropriate box)*

<table>
<thead>
<tr>
<th>Suspected</th>
<th>Probable</th>
<th>Confirmed</th>
<th>Non-case</th>
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