Hemorrhagic Fever Surveillance Form

Vial Number:

Name and location of Health Center:

Name of physician or nurse:

Contact address **(Important: to receive results, give a very specific contact address)**:

Telephone/Fax number:

Patient data Hospital Number:
Name:
Age:
Sex: __Male __Female
Address:

Profession or occupation:
Date of first symptoms: Date of admittance:
Date of death: Date of biopsy:
If patient was not hospitalized, who cared for the patient?

Are any other family members ill? If yes, relationship:
Symptoms of family member:

If the patient was hospitalized, use the table attached to mark the symptoms you observed and any other important observations.

Clinical Signs and Symptoms Form

Name of Patient:

Symptoms (Check each one present)	**Date of appearance:**
☐ Fever	
☐ Diarrhea	
☐ Extreme weakness after rehydration	
☐ Nausea	
☐ Vomiting	
☐ Sore Throat	
☐ Headache	
☐ Loss of appetite	
☐ Muscle pain	
☐ Joint pain	
☐ Hiccups	
☐ Cough	
☐ Conjunctivitis	
☐ Chest pain	
☐ Rapid respiration	
☐ Recent loss of hearing	
☐ Burning sensations of the skin	
Bleeding, specify below:	**Date of appearance:**
☐ Black or bloody vomit	
☐ Black or bloody stool	
☐ Mouth	
☐ Nose	
☐ Urine	
☐ Skin or puncture site	
☐ Other bleeding: (specify)	
Other Observations:(specify)	

Selection criteria for testing of suspected viral hemorrhagic fever (VHF)

Patient's last name, first name:

When to obtain a skin biopsy sample for testing:

The patient had the following symptoms within 2 weeks preceding death:

- ☐ Fever and
- ☐ Diarrhea and

One of the following signs:

- ☐ Headache
- ☐ Intense weakness after rehydration
- ☐ Muscle pains
- ☐ Joint pains
- ☐ Back pains

↓

Treatment was given with antibiotics and antimalarials for a minimum of 3 days.

↓

The patient failed to respond to treatment with no definitive diagnosis and died with at least 3 of the following:

- ☐ Sore throat or difficulty in swallowing
- ☐ Red eyes
- ☐ Skin eruptions
- ☐ Hiccups
- ☐ Burning sensation of the skin
- ☐ Bleeding: nose, mouth, urine, stools (black or bloody), or vomit (black or bloody)
- ☐ Rapid respiration
- ☐ Patient reports another similar death in the family within last 10 days*

* Measures should be taken to put the family and contacts under surveillance.

Obtain a skin biopsy sample, following the instructions given in this document. The biopsy sample is not infectious once in formalin or chaotrope.

Send it to CDC for testing at the following address:

Special Pathogens Branch, CDC
1600 Clifton Rd., MS G-14
Atlanta, GA 30333, USA
Telephone: (404) 639-1115
TELEX 549571CDCATL