

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

**HEMORRHAGIC FEVER VIRUS INFECTION
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 68**

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U

If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CHECK ALL THAT APPLY:

Fever Y N U

Yes, subjective No Yes, measured Unknown

Highest measured temperature _____

Fever onset date (mm/dd/yyyy): ___/___/___

Fatigue or malaise or weakness Y N U

Shock Y N U

Was systolic BP <90mm Hg Y N U

Shock was: Septic Hypovolemic

Hemorrhagic Y N U

Altered mental status Y N U

Patient displayed (select all that apply)

Confusion Coma Delirium Anxiety/apprehension Dementia

Muscle aches/pains (myalgias) Y N U

Skin rash Y N U

Onset date (mm/dd/yyyy) _____

Location:

All over the body (generalized) Generalized, predominantly central/torso/back (centripetal) Generalized, predominantly face/hands/feet (centrifugal) Localized/focal Palms and soles

Appearance (select all that apply)

Macular Petechial Papular Unknown Vesicular

Bruising (echymoses) Y N U

Disseminated intravascular coagulation (DIC) Y N U

Thrombocytopenia (platelets < 100,000/mm³) Y N U

Hemorrhagic symptoms/signs Y N U

Specify (check all that apply): Vaginal bleeding Melena Other

Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U

Specify: _____

Restrictions to movement or freedom of action? Y N

Check all that apply:

Work Sexual behavior Child care Blood and body fluid School Other, specify _____

Date control measures issued: ___/___/___

Date control measures ended: ___/___/___

Was patient compliant with control measures? Y N

Discharge/Final diagnosis: _____

Did patient have a travel history during the 21 days prior to onset? Y N U

List travel dates and destinations:

From ___/___/___ to ___/___/___

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? Y N

If yes, specify: _____

Were written isolation orders issued? Y N U

If yes, where was the patient isolated? _____

Date isolation started: ___/___/___

Date isolation ended: ___/___/___

Was the patient compliant with isolation? Y N U

Were written quarantine orders issued? Y N

If yes, where was the patient quarantined? _____

Date quarantine started: ___/___/___

Date quarantine ended: ___/___/___

Was the patient compliant with quarantine? Y N

Notes:

CLINICAL OUTCOMES

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ___/___/___

TREATMENT

Did the patient receive an antiviral for this illness? Y N U

Antiviral name _____

Was antiviral prophylaxis given prior to illness onset? Y N U

Did the patient require mechanical ventilation? Y N U

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U
 Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) _____ - _____
 Admit date (mm/dd/yyyy): ____/____/____
 Discharge date (mm/dd/yyyy): ____/____/____
 Number of days hospitalized at time of report: _____

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 Foreign Visitor
 Refugee
 Recent Immigrant
 Foreign Adoptee
 None of the above

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U
 List persons and contact information:

Additional travel/residency information:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
 Patient a child care worker or volunteer in child care? Y N U
 Patient a parent or primary caregiver of a child in child care? Y N U
 Is patient a student? Y N U
 Type of school: _____
 Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U
 Give details: _____

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 21 days prior to onset of symptoms, did the patient have any health care exposures such as hospitalization, ER visit, outpatient clinic, long term or other institutional care? Y N U
 Nature of exposure: _____
 Name of facility: _____
 Location/address: _____
 City: _____ State: _____
 Zip code: _____

Telephone: (____) _____ - _____
 Other occupation, specify: _____

Puncture or accidental stick with needle or other object known to be or possibly contaminated with blood? Y N U
 Please provide details of puncture or stick: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 21 days prior to onset of symptoms did the patient attend social gatherings or crowded settings? Y N U
 If yes, specify: _____

In what setting was the patient most likely exposed?
 Restaurant Place of Worship
 Home Outdoors, including woods or wilderness
 Work Athletics
 Child Care Farm
 School Pool or spa
 University/College Pond, lake, river or other body of water
 Camp Hotel / motel
 Doctor's office/ Outpatient clinic Social gathering, other than listed above
 Hospital In-patient Travel conveyance (airplane, ship, etc.)
 Hospital Emergency Department International
 Laboratory Community
 Long-term care facility /Rest Home Other (specify) _____
 Military Unknown
 Prison/Jail/ Detention Center

ANIMAL EXPOSURE

During the 21 days prior to onset of symptoms: Did the patient have exposure to household pets or other animals (includes animal tissues, animal products, or animal excreta)? Y N U
 Specify animal(s) _____

Did patient work with animal importation? Y N U
 Did the patient work at or visit a zoo, zoological park, or aquarium? Y N U
 Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U
 Provide the nature of contact, dates, location, and other specifics for any question answered yes.

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 If yes, specify: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____
 Were interviews conducted with others? Y N U
 Who was interviewed? _____

Were health care providers consulted? Y N U
 Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
 Specify reason if medical records were not reviewed: _____

Notes on medical record verification: _____

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
 Specify location:
 In NC
 City: _____
 County: _____
 Outside NC, but within US
 City: _____
 State: _____
 County: _____
 Outside US
 City: _____
 Country: _____
 Unknown

Is the patient part of an outbreak of this disease? Y N
 Notes: _____

Hemorrhagic Fever Virus Infection

2008 North Carolina Case Definition

Viral hemorrhagic fevers (VHFs) are caused by viruses in four distinct families: arenaviruses, filoviruses, bunyaviruses, and flaviviruses. Some of the more common viruses are recognized by disease names such as Ebola, Marburg, and Lassa, Crimean-Congo hemorrhagic and Rift-Valley fevers.

Clinical description

Signs and symptoms vary by the type of VHF. Early/prodromal manifestations often include high fever, dizziness, muscle aches, loss of strength, and exhaustion. Patients with severe cases of VHF often develop bleeding under the skin, in internal organs, or from body orifices like the mouth, eyes, or ears. However, patients rarely die from blood loss. Laboratory tests often reveal thrombocytopenia ($\leq 100,000$ platelets/mm³), hemoconcentration (i.e., hematocrit increased by $\geq 20\%$) or other evidence of plasma leakage. Severely ill patients may develop shock, delirium, seizures, coma, or multi-system organ failure.

Laboratory criteria for diagnosis

(NOTE: Laboratory confirmation represents an extreme biohazard. Viral isolation should only be attempted at CDC or another biosafety level 4 laboratory.)

- Demonstration of immunoglobulin G (IgG) or immunoglobulin M (IgM) antibody titers to one or more virus antigens in a blood or serum sample, or
- Demonstration of antigen in tissue or serum/blood samples by antigen-detection enzyme-linked immunosorbent assay (ELISA) or immunohistochemistry; detection of viral genome in blood/serum by polymerase chain reaction (PCR); or detection of virus in tissues by electron microscopy, or
- Isolation of virus from serum and/or tissue samples.

Case classification

Suspect: Any clinically compatible illness suspected by a health care provider of being VHF, AND having an epidemiologic link as described below.

Probable: A clinically compatible case that is epidemiologically linked to a confirmed case.

Confirmed: A clinically compatible case that is laboratory confirmed.

Criteria for epidemiologic linkage

One or more of the following exposures within the *3 weeks before onset of symptoms*:

- contact with blood or other body fluids- or materials contaminated with blood or body fluids- from a patient with suspected VHF,
- residence in or travel to a VHF endemic area,
- work in a laboratory that handles VHF specimens, *or*
- work in a laboratory that handles animals from VHF endemic areas;

OR exposure to semen from a suspected case of Ebola or Marburg VHF within the *6 weeks before onset of symptoms*.