

EBOLA DISEASE CASE INVESTIGATION FORM

PHU

ID

Interviewer

Telephone

Case interviewed No
 Yes

Person interviewed (if not case)

Interview date

Interview time

NOTIFICATION

Date of notification ___/___/___

Date of initiation of response ___/___/___

First Notifier

Telephone

Fax

Notifier type Laboratory
 Doctor
 Hospital (not laboratory)
 Other – specify

Received date ___/___/___

Treating doctor

Name

Address

Practice name

Telephone

Fax

Email

CASE FOUND BY

How case was identified Clinical presentation Contact tracing / epidemiological investigation
 Screening Clinical and epidemiology
 Unknown

PLACE OF ACQUISITION

Place infection acquired Overseas (country known) Overseas (country unknown)
 Australia (postcode known) Australia (State or Territory known, postcode unknown) Australia (postcode unknown)

Country acquired (if known)

Country code (use valid SACC) _____

CASE DEMOGRPAHICS

Surname

Given name

Sex at birth

Gender at diagnosis

- Male
 Female
 X (another term) - specify _____
 Not stated

- Man or male
 Woman or female
 Non-binary
 Other - specify _____
 Not stated

DOB ___ / ___ / ___

Age at onset ___ years ___ months

Address

Suburb

State /
Territory

Postcode

Telephone

Mobile

Email

Other
contact

Telephone

Indigenous
status

- Aboriginal
 Torres Strait
Islander
 Both
 Aboriginal and
Torres Strait
Islander
 Not
Indigenous
 Not stated

Country of
birth

- Australia
 Other:
specify _____

Primary
language

- English
 Other:
specify _____

Interpreter
required

- No
 Yes: specify _____

Occupation

Work details

Name of
workplace /
school

Address

Contact person

Telephone

General
Practitioner

Name

Address

Practice name

Telephone

Fax

CLINICAL DETAILSSymptoms present Yes No Unknown

Onset of first symptoms Date ___/___/___ Time: _____ AM / PM

Febrile phaseFever $\geq 38^{\circ}\text{C}$, shakes or chills Yes No Unknown

If yes, date of fever onset ___/___/___ Time: _____ AM / PM

Highest measured temperature _____ $^{\circ}\text{C}$ Date measured ___/___/___

Malaise

 Yes No Unknown

Myalgia

 Yes No Unknown

Headache

 Yes No Unknown

Pharyngitis

 Yes No Unknown

Conjunctival injection

 Yes No Unknown

Vomiting

 Yes No Unknown

Diarrhoea

 Yes No Unknown

Bloody diarrhoea

 Yes No Unknown

Abdominal pain

 Yes No Unknown

Rash

 Yes No Unknown

Petechiae

 Yes No Unknown

Other signs or symptoms

 Yes No Unknown

If Yes, provide details

Complications

Hypotension

 Yes No Unknown

Spontaneous bleeding

 Yes No Unknown

Oedema

 Yes No Unknown

Shock

 Yes No Unknown

Neurologic involvement

 Yes No Unknown

Multi-organ failure

 Yes No Unknown

Other complications – specify _____

Additional clinical information

Details of other abnormal findings (e.g. haematology, biochemistry, imaging)

Existing medical conditions

 Yes No Unknown

If Yes, provide details

Pregnancy status

 Yes No Post-birth (infection detected at or after delivery)

Unknown
If Yes, number of weeks gestation _____

LABORATORY

Specimens collected Blood/serum Throat swab Urine

Date collected ___/___/___ ___/___/___ ___/___/___

Receiving laboratory _____

Specimens transferred to jurisdictional public health laboratory (if relevant) Yes No Unknown

Detection of virus by PCR in jurisdictional public health laboratory (if relevant) Yes No Unknown

Specimens transferred to NHSQL Yes No Unknown

Confirmation by Victorian Infectious Diseases Reference Laboratory
 Other (specify) _____

Isolation of virus Yes No Unknown

Detection of virus by PCR Antigen detection Electron microscopy

IgG titre(s) Single high titre Titre _____ Date ___/___/___

Fourfold rise First titre _____ Date ___/___/___

IgM positive Yes No Unknown or not done
Date ___/___/___

Lymphopenia Yes No Unknown

Thrombocytopenia Yes No Unknown

VACCINATION HISTORY

Vaccinations

Dose	Vaccination type	Vaccination date	Validation method
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1

2

HOSPITAL ADMISSION

Yes No Unknown
Hospitalised If Yes, hospital name _____
Date admitted ___/___/___ Date discharged ___/___/___

Isolated in a single room Yes No Unknown
If Yes:
Negative pressure isolation room? Yes No Unknown
Included anteroom? Yes No Unknown

Treating doctor Name _____ Position _____
Telephone _____

ICU or HDU admission Yes – ICU Yes – HDU No Unknown
If Yes, dates of ICU or HDU admission __/__/__ to __/__/__

Mechanical ventilation Yes No Unknown

TREATMENT DETAILS

Treatment	Dose	Frequency	Route	Commencement date	Completion date
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EXPOSURE HISTORY

Exposure Period
Date: __/__/__ to __/__/__
(onset of symptoms minus 21 days) (onset of symptoms minus 1 day)

Exposure to infectious case

Contact with a confirmed or probable case/ during this time Yes No Unknown
If Yes, date of last contact with a case __/__/__
If Yes, location of last contact with a case _____

Case 1 name _____

Case 1 type Living patient Deceased patient

Type of contact Visit sick patient Care for sick patient

Specify type of care _____

later got sick Bury deceased patient Sexual contact of survivor or someone who

Exposed to blood, saliva, urine, vomit or faeces of sick patient

Exposed to blood, saliva, urine, vomit or faeces of deceased patient

Briefly saw patient, but did not touch

Other (specify) _____

Duration of contact _____

Case 2 name _____

Case 2 type Living patient Deceased patient

Type of contact Visit sick patient Care for sick patient

Specify type of care _____

later got sick Bury deceased patient Sexual contact of survivor or someone who

Exposed to blood, saliva, urine, vomit or faeces of sick patient

Exposed to blood, saliva, urine, vomit or faeces of deceased patient

Briefly saw patient, but did not touch

Other (specify) _____

Duration of contact _____

Occupational exposures

If Yes to Exposure to infectious case:

Was appropriate PPE used? Yes No Unknown

Details of PPE used

Did any PPE breach occur? Yes No Unknown

Details of PPE breach

Animal exposures

Contact with bats, primates or other animals from disease-endemic area?

Yes No Unknown

Contact with people who are in close contact with bats or primates from disease-endemic areas?

Yes No Unknown

Laboratory exposure

Was there a laboratory exposure?

Yes No Unknown

Healthcare exposure

Did the case visit a healthcare facility or hospital during their exposure period?

Yes No Unknown If Yes, date last attended: ___/___/___

Any other exposure

For any exposure

Location of possible exposure _____

Nature of possible exposure – specify _____
Dates of possible exposure ____/____/____

TRAVEL HISTORY (EXPOSURE PERIOD)

Country visited	Date / time of arrival	Airline and flight number	Seat number	Date / time of departure	Airline and flight number	Seat number
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INFECTIOUS PERIOD

Between dates ____/____/____ (onset of symptoms) to
____/____/____ (10 weeks after onset or as long as blood/secretions contain virus)

Isolation commenced Yes No Unknown If Yes, date isolation commenced ____/____/____

Details of isolation _____

Did the case travel during their infectious period

Yes No Unknown If Yes, detail all places visited below

Place visited	Arrival date	Departure date	Flight number or mode of transport
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Did the case attend any of the following during their infectious period?

Childcare Name Phone Date attended ____/____/____

Preschool/school Name Phone Date attended ____/____/____

Educational or residential facility Name Phone Date attended ____/____/____

Hospital or healthcare facility Name Phone Date attended ____/____/____

CONTACTS

Contact setting	Name	Contact details	Level of risk*
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Household

Ambulance staff

Medical and healthcare
staff

Laboratory staff

Work

Sexual

Other – specify

OUTCOME

Notification decision Confirmed – Ebola disease case
 Probable – Ebola disease case
 Suspected
 Alternative diagnosis made (detail next page)

Additional details for alternative diagnosis

Alternative diagnosis _____

Supporting microbiological evidence Yes No Unknown

If Yes, specify details _____

Case recovered Yes No Unknown
Case died Yes No Unknown
If Yes, was autopsy conducted Yes No Unknown
Results of autopsy
 Died of notified condition Died of other cause

Notes

ADMINISTRATION

Completed by

Date finalised __/__/__

PHU

*Assessment of contacts and determination of level of risk is outlined in the [Ebola disease Series of National Guidelines](#) (SoNG). Instructions for unlikely exposure, lower risk of exposure, and higher risk of exposure contacts are provided in the SoNG.