

VIRAL HEMORRHAGIC FEVER CONTACT INVESTIGATION WORKSHEET FOR SYMPTOMATIC SUSPECT OR CONFIRMED CASE



Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone), 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

Investigator Name: _____ Investigator Phone: _____ Date of Interview: _____

CASE INFORMATION

Case IRIS ID	Case Name (Last, First)	Case Date of Birth	Case Phone	Symptom Onset Date	Isolation Date	If Case Unavailable, Name of Person Interviewed.	Relationship to Case	Alternate Person's Phone

Instructions: After conducting the VHF Suspect Intake and Checklist interview, use this contact investigation form to elicit all contacts exposed to the suspect/confirmed Viral Hemorrhagic Fever case after the symptom onset date. Record all information regarding exposed contacts on this form

Script: Now I'm going to ask you about any people you may have had direct or close contact (3 feet to 1 meter) after your symptoms began on [Insert Symptom o]. Please provide detailed information about each contact as much as possible. LAC DPH will need to reach out to these close contacts to notify them of their exposure so that they can self-monitor, quarantine and be informed of what they should do to keep themselves and their family safe. Your name will not be disclosed to the contact who we call. Will you be providing us with a list of recent contacts?

EVD Patient: ☐ Consented to Provide Contacts ☐ Refused to Provide Contacts

POSSIBLE CONTACTS

Since your symptoms first began on _____,	Yes	No	Instructions
HOUSEHOLD CONTACTS			
Who have you been living with?	<input type="checkbox"/>	<input type="checkbox"/>	[Record names and dates/Note on Pg.5]
Who else spent time at your home (eating meals, hanging out, sleeping over, used a share bathroom) but doesn't live with you?	<input type="checkbox"/>	<input type="checkbox"/>	[Record names and dates/Note on Pg.5]
Who has slept in the same room with you?	<input type="checkbox"/>	<input type="checkbox"/>	[Record names and dates/Note on Pg.5]
Who has taken care of you or cleaned up after you at home? (e.g.: laundry, washing utensils)	<input type="checkbox"/>	<input type="checkbox"/>	[Record names and dates/Note on Pg.5]
Do you have a household member who is under your care? (e.g.: children, chronically ill family member)	<input type="checkbox"/>	<input type="checkbox"/>	[Record names and dates/Note on Pg.5]
Do you have a pet that is under your care?	<input type="checkbox"/>	<input type="checkbox"/>	[Record/Note on Pg.5]
SEXUAL CONTACTS			
Did you have any sexual contacts?	<input type="checkbox"/>	<input type="checkbox"/>	[Record names and dates/Note on Pg.5]
HEALTHCARE CONTACTS			
Did you visit a health care facility (HCF)?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Facility name _____ Address _____ Phone _____ Dates visited _____ Type of Facility: <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other: _____ Method of Visit: <input type="checkbox"/> Private/Personal vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Uber/Lyft/Ride Share <input type="checkbox"/> Other: _____ Who had direct physical contact with you*? [Record names on Pg.5]
Did you visit more than one HCF?	<input type="checkbox"/>	<input type="checkbox"/>	Please record the above information in Notes.

POSSIBLE CONTACTS (CONTINUED)

Since your symptoms first began on [Insert symptom onset ,		YES	NO	Instructions
TRAVEL CONTACTS	Did you travel outside of LAC?	<input type="checkbox"/>	<input type="checkbox"/>	<p>If Yes, Mode of travel: <input type="checkbox"/> Plane <input type="checkbox"/> Taxi <input type="checkbox"/> Bus <input type="checkbox"/> Cruise <input type="checkbox"/> Uber/Lyft/Ride Share</p> <p><input type="checkbox"/> Other _____</p> <p>Bus line/train line/cruise flight number: _____</p> <p>Where did your travel originate? _____</p> <p>What was your destination? _____</p> <p>Address of Hotel/Airbnb/House: _____</p> <p>Dates of travel: _____</p> <p>Who traveled with you or had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i></p>
WORKPLACE CONTACTS	Employed?	<input type="checkbox"/>	<input type="checkbox"/>	<p>If Yes, Business name _____</p> <p>Address _____</p> <p>Phone (____) _____ Supervisor _____</p> <p>Dates went to work: _____</p> <p>Dates teleworked: _____</p> <p>Who are the people that you had direct physical contact with or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i></p>
SCHOOL CONTACTS	Did you go to school?	<input type="checkbox"/>	<input type="checkbox"/>	<p>If Yes, School name _____</p> <p>Address _____</p> <p>Phone (____) _____ Principal/Administrator _____</p> <p>Dates attended _____</p> <p>Classes _____</p> <p>Who are the people that you had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i></p>
SOCIAL EVENT CONTACTS	Did you attend any organized social event such as a party?	<input type="checkbox"/>	<input type="checkbox"/>	<p>If Yes, Event name _____</p> <p>Address _____</p> <p>Host name _____ Phone (____) _____</p> <p>Dates of event _____</p> <p>Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i></p>

POSSIBLE CONTACTS (CONTINUED)

Since your symptoms first began on _____, _____		YES	NO	Instructions
BARS/CLUBS CONTACTS	Did you attend any bars or clubs?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Bar/Club name _____ Address _____ Dates visited _____ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i>
FRIEND'S OR RELATIVE'S HOME	Did you go to friend's or relative's homes?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Friend or relative name _____ Address _____ Dates visited _____ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i>
COMMUNITY CENTERS	Did you go to any community centers?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Community center name _____ Address _____ Dates visited _____ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i>
RELIGIOUS SERVICE CONTACTS	Did you go to any religious services?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Church/Temple/Mosque Name _____ Address _____ Dates visited _____ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i>
OTHER ACTIVITIES OR PLACES	Did you participate in any other activities or visit any other places (e.g.: gyms, group activities, concerts)?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Place name _____ Address _____ Dates visited _____ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i>
OTHER	Is there anyone else who may have had direct contact with your skin, blood and/or other body fluids (blood, tears, saliva, vomit, diarrhea, urine, breast milk, sweat, semen)?	<input type="checkbox"/>	<input type="checkbox"/>	Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i>
	Is there anyone else who may have touched any objects that may have been contaminated with your bodily fluids?	<input type="checkbox"/>	<input type="checkbox"/>	Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? <i>[Record names on Pg.5]</i>
	Did you throw away any personal disposable items (e.g.: tissues, toothbrush, water bottle, diaper, sanitary pad, towels) that may have been contaminated with you bodily fluids?	<input type="checkbox"/>	<input type="checkbox"/>	Where are the disposed items currently:
MODE OF USUAL TRANSPORT	What is your usual mode of transport for your commute to work, school, and/or other errands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Personal Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Uber/Left/Rideshare <input type="checkbox"/> Taxi <input type="checkbox"/> Train <input type="checkbox"/> Other: _____ Provide the dates of when you used mass transits/ride share: _____ Provide details of the mass transits/ride share: _____

IF CASE DIED BEFORE EVD DIAGNOSIS, ASK THE FOLLOWING TO ALTERNATE CONTACT:

FUNERAL/ BURIAL	Was there a viewing, a wake or a service for the case?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Address of viewing, wake, or service. _____ Funeral Home/Mortuary Name _____ Address _____ Phone _____ Who had direct physical contact with the body? <i>[Record names on Pg.5]</i>
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NOTES:

Case name (last, first) _____

IRIS ID# _____

CONTACT INFORMATION LIST

	FULL NAME	DOB	AGE	SEX	RELATIONSHIP TO CASE	DATE OF LAST CONTACT WITH CASE	TYPE OF CONTACT	EXPOSURE LOCATION (If HCF, provide facility name)	*RISK LEVEL	HEALTHCARE WORKER?	PHONE	RESIDENTIAL ADDRESS	CITY	ADDITIONAL NOTES
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3														
4														
5														
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8														
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***Risk Classification:** Refer to the B-73 for the suspected disease**Types of Contact:**

- 1 = Had contact of percutaneous, mucous membrane or broken skin contact with blood or other body fluids (blood, saliva, tears, vomit, diarrhea, urine, breastmilk, sweat, semen) of the patient
- 2 = Had direct physical contact with the body of the patient (alive or dead).
- 3 = Touched or cleaned the personal belonging, bedding, linens, clothes, or dishes of the patient.
- 4 = Slept or ate in the same household as the patient.
- 5 = No physical contact but was within 3 feet or 1 meter with the patient.

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