

**SUSPECT VIRAL HEMORRHAGIC FEVER (VHF)
INTAKE AND CHECKLIST**



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/acdc/

AOD Name:	Today's Date:	Time:
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REPORTING VIRAL HEMORRHAGIC FEVER:		
<input type="checkbox"/> Arenavirus – New World <input type="checkbox"/> Chapare <input type="checkbox"/> Guanarito <input type="checkbox"/> Junin <input type="checkbox"/> Machupo <input type="checkbox"/> Sabia	<input type="checkbox"/> Arenavirus – Old World <input type="checkbox"/> Lassa Fever <input type="checkbox"/> Lujo <input type="checkbox"/> Alkhurma hemorrhagic fever <input type="checkbox"/> Ebola <input type="checkbox"/> Crimean-Congo hemorrhagic fever	<input type="checkbox"/> Kyasanur Forest disease <input type="checkbox"/> Marburg <input type="checkbox"/> Nipah virus <input type="checkbox"/> Rift Valley fever <input type="checkbox"/> Omsk hemorrhagic fever <input type="checkbox"/> Other:

Reporting Facility:		Type of Facility:		Phone:	
Facility Address:		City:	Zip Code:	Facility in LAC? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Physician/Reporter Name:		Phone:		Email:	
Infection Preventionist/ DON:		Phone:		Email:	
Physician Contact for updates:		Phone:		Email:	

PATIENT INFORMATION:							
Last Name:		First Name:		Date of Birth:		Age: <small><input type="checkbox"/> Month <input type="checkbox"/> Year</small>	
Gender:	Pregnant? <input type="checkbox"/> Yes, EDD: <input type="checkbox"/> No <input type="checkbox"/> Unknown	Breast Feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight (lbs):		Height:		
Occupation:		Occupation Location in US:			Work Phone:		
Healthcare worker? YES NO		Worked in affected country? YES NO			Working for nonprofit organization (NGO)? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Country of Residence:		Preferred Language:		Translator Needed? <input type="checkbox"/> YES <input type="checkbox"/> NO		Passport Number:	
Home Phone:		Cell Phone:		Email:		Name of NGO:	
Current Address:		City:		Zip Code:		NGO Contact Phone:	
Type of Residence in US: <input type="checkbox"/> Apartment <input type="checkbox"/> Condo <input type="checkbox"/> House <input type="checkbox"/> Mobile Home <input type="checkbox"/> Town House <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Congregate Setting:							
Number of household members in US residence:		Type of pets:		Number of pets:			
Emergency/Guardian Contact:		Phone:		Does Contact has Access to Residence? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			
Mode of Arrival to Reporting Facility: <input type="checkbox"/> Ambulance <input type="checkbox"/> Airlift <input type="checkbox"/> Bus <input type="checkbox"/> Uber/Lyft/Rideshare <input type="checkbox"/> Taxi <input type="checkbox"/> Personal Vehicle <input type="checkbox"/> Other:							
<input type="checkbox"/> Pasadena Resident – Refer to Pasadena HD at (626) 744-6005 General, (626) 744-6089 PH Nursing, (626) 744-6043 After-hours <input type="checkbox"/> Long Beach Resident – Refer to Long Beach HD at (562) 570-4000 General, (562) 570-4302 Epidemiology <input type="checkbox"/> Other Out of Jurisdiction County/State/Country:							

TRAVEL HISTORY: In the past 21 days, did the patient participate in the following:			
<input type="checkbox"/> Live in or Traveled to a Country(s) with VHF transmission – check CDC website for the most recent list of OB areas:			
Country(s) Patient Lives in or Traveled From:			
Dates of Arrival to Country(s):		Date of Departure from Country(s):	
Date of Arrival to U.S.:		Date of Arrival to U.S.:	
U.S. Airport Arrived:	Airline:	Flight Number:	Reason for Travel:
Usual Activities while in VHF Endemic Area:			

EXPOSURE HISTORY: In the past 21 days, did the patient participate in the following:	
Possible Exposure Type	Last Date of Exposure
<input type="checkbox"/> Have contact of percutaneous, mucous membrane or broken skin contact with blood or other body fluids (blood, tears, vomit, diarrhea, urine, breast milk, sweat, semen) of a person with suspected or confirmed VHF. <input type="checkbox"/> Blood <input type="checkbox"/> Respiratory Secretions <input type="checkbox"/> Vomitus <input type="checkbox"/> Sweat <input type="checkbox"/> Semen <input type="checkbox"/> Stool/Diarrhea <input type="checkbox"/> Urine <input type="checkbox"/> Other:	
<input type="checkbox"/> Have contact with surfaces, medical equipment, personal belongings, or materials (e.g.: bedding, clothes) possibly contaminated with bodily fluids of a person with suspect or confirmed VHF.	
<input type="checkbox"/> Health care worker who provided direct care or environmental cleaning at a facility that may have had patient with known or suspected VHF. <input type="checkbox"/> Breach in infection control precautions or personal protective equipment (including needlestick injuries). Describe Below in Notes.	
<input type="checkbox"/> Worked in or visited a Healthcare Facility or a Traditional Healer that have treated VHF patients.	
<input type="checkbox"/> Laboratory worker in a facility where human specimens and/or bats, rodents or primates from endemic areas are handled <input type="checkbox"/> Breach in infection control precautions or personal protective equipment (including needlestick injuries). Describe Below in Notes.	
<input type="checkbox"/> Have close contact (within 3 feet or 1 meter) with a person who has known or suspected VHF.	
<input type="checkbox"/> Have close contact (within 3 feet or 1 meter) with a person who was sick/have a fever of an unknown disease.	
<input type="checkbox"/> Live in the same household as a person with symptomatic known or suspected VHF. Present in any healthcare facility (including outpatient settings and traditional healers) while in the outbreak area. Had direct contact/in close proximity near an animal or a animal nesting site/cave/mines in an endemic country. Describe Below in Notes. <input type="checkbox"/> Bats <input type="checkbox"/> Camels <input type="checkbox"/> Domestic animals(pigs) <input type="checkbox"/> Antelope/Duikers <input type="checkbox"/> Livestock <input type="checkbox"/> Primates(monkey, apes) <input type="checkbox"/> Rodents <input type="checkbox"/> Other, describe in Notes	
<input type="checkbox"/> Consumed animal/bush meat or food contaminated by animals in an endemic country. Describe Below in Notes. <input type="checkbox"/> Bats <input type="checkbox"/> Camels <input type="checkbox"/> Domestic animals(pigs) <input type="checkbox"/> Antelope/Duikers <input type="checkbox"/> Livestock <input type="checkbox"/> Primates(monkey, apes) <input type="checkbox"/> Rodents <input type="checkbox"/> Other, describe in Notes	
<input type="checkbox"/> Was bitten or near insects while traveling. <input type="checkbox"/> Ticks (Bitten, crushed with fingers) <input type="checkbox"/> Mosquitoes <input type="checkbox"/> Other:	
<input type="checkbox"/> Participate in funeral and/or burial rituals and/or contact of a body of a deceased person with suspected or confirmed VHF.	
<input type="checkbox"/> Other Possible Exposure Type:	

EXPOSURE NOTES:

CURRENT MEDICAL INFORMATION						
Symptom Onset Date:	Hospitalized:	Hospital Name:	Admission Date:	Unit Type (e.g.: ICU)	Isolated Room?	MRN:
	<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Was Patient Transferred from another healthcare facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, from which healthcare facility:						
Current Disposition: <input type="checkbox"/> ED <input type="checkbox"/> Admitted <input type="checkbox"/> Alive <input type="checkbox"/> AMA <input type="checkbox"/> Intubated <input type="checkbox"/> Expired, Date of Death: <input type="checkbox"/> Other:						
Current Disposition Address:			City:	Zip Code:		
Current Medications:						
Allergies to Medication:						
Medication Prescribed:						
Treatment/Procedure Provided:						
Patient Currently Menstruating? <input type="checkbox"/> YES <input type="checkbox"/> NO, Last Period Date:			<input type="checkbox"/> Unknown <input type="checkbox"/> NA	Is the Patient Alert? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		
Does the Patient Need Assistance to Ambulate? <input type="checkbox"/> YES <input type="checkbox"/> NO			If Yes, what specify needed assistance:			
SIGNS AND SYMPTOMS (CHOOSE ALL THAT APPLY):						
Fever (subjective or $\geq 100.4^{\circ}\text{F}/38.0^{\circ}\text{C}$) <input type="checkbox"/> YES <input type="checkbox"/> NO	Maculopapular or Petechial Rash <input type="checkbox"/> YES <input type="checkbox"/> NO		Unexplained hemorrhage (bleeding not related to injury) or Bruising <input type="checkbox"/> YES <input type="checkbox"/> NO			
Highest Fever Recorded: ($^{\circ}\text{F} / ^{\circ}\text{C}$)	Location:		Location:			
Severe Headache <input type="checkbox"/> YES <input type="checkbox"/> NO	Abdominal Pain / Cramping <input type="checkbox"/> YES <input type="checkbox"/> NO					
Neurological Symptoms <input type="checkbox"/> YES <input type="checkbox"/> NO	Vomiting / Nausea <input type="checkbox"/> YES <input type="checkbox"/> NO		Bloody Vomit or Diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO			
Weakness <input type="checkbox"/> YES <input type="checkbox"/> NO	Diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO		Chest Pain <input type="checkbox"/> YES <input type="checkbox"/> NO			
Fatigue / Exhaustion <input type="checkbox"/> YES <input type="checkbox"/> NO	Body Aches/Sore Muscles or Joint Pain <input type="checkbox"/> YES <input type="checkbox"/> NO		Other Symptoms, describe below in Notes <input type="checkbox"/> YES <input type="checkbox"/> NO			
Signs and Symptoms Notes:						
Person Currently Has:						
<input type="checkbox"/> Dry Symptoms <input type="checkbox"/> Wet Symptoms <input type="checkbox"/> Expired, Date of Death:						
If Died, Place of Death:			Current Location of the Body:			
Next of Kin/Point of Contact Name:			Relationship to Decedent:		Phone Number:	
ANY RECENT RELEVANT DIAGNOSIS/ LABORATORY TEST RESULTS:						
Recently Positive for Malaria? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			If Yes, date of diagnosis:			
Test Positive for Any Other Infection? <input type="checkbox"/> YES <input type="checkbox"/> NO			If Yes, specify:			
Specify Other Recent Diagnosis/ Abnormal Laboratory Findings:						
SPECIMEN AVAILABILITY						
Patient Blood Specimens Collected and Still Available? <input type="checkbox"/> YES <input type="checkbox"/> NO			If Yes, Collected in what tube: <input type="checkbox"/> Lavender Top <input type="checkbox"/> Red Top/SST <input type="checkbox"/> Other:			
If Yes, Date of Collection:		How Much Left: ml	Location of Available Tube:			
Phone Number of the Location:			Point of Contact for Available Specimen:			
PAST MEDICAL HISTORY						
Describe Any Significant Underlying Conditions/ Comorbidities:						
<input type="checkbox"/> Diabetes <input type="checkbox"/> HIV, CD4 Count: <input type="checkbox"/> Hypertension <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Hepatitis, specify in Notes below <input type="checkbox"/> Malignancy, specify in Notes below						
<input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Dementia <input type="checkbox"/> Other:						
Immunocompromised? <input type="checkbox"/> YES <input type="checkbox"/> NO						
Previously Recovered from a VHF?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	Which VHF:		Date of Recovery:		
Received EVD Vaccination?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If YES, provide the date:				
Received Malaria Prophylaxis?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If YES, provide the date:				
Received Yellow Fever Prophylaxis?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If YES, provide the date:				
Received Typhoid Vaccination?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If YES, provide the date:				
Received Dengue Fever Vaccination?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If YES, provide the date:				
Received COVID-19 Vaccination	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If YES, provide the date:				
Received Influenza Vaccination?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	If YES, provide the date:				
PAST MEDICAL HISTORY NOTES:						

PROVIDER EDUCATION/RECOMMENDATIONS

No identified Risk Factors (no exposure history) – continue usual triage and assessment. No ACDC follow-up necessary.

Identified Risk Factors (1 or more exposure history)

Symptomatic – Isolate the patient and determine PPE equipment needed (below in “Infection Control Recommendations for Symptomatic Patient”).

Asymptomatic – continue usual triage and assessment. Monitoring new symptoms for 21 days after last exposure will be determined by ACDC.

CONTACTS / OTHER ILL PERSONS

Any close contacts with similar illness (including household contacts)? YES NO UNKNOWN

Refer to VHF Contact Investigation Worksheet to Identify Close Contacts: <http://publichealth.lacounty.gov/acd/Diseases/EpiForms/>

INFECTION CONTROL RECOMMENDATIONS FOR SYMPTOMATIC PATIENT

Component	Recommendation
Patient Placement	<ul style="list-style-type: none"> ○ Single patient room (private bathroom) with door closed ○ Only essential personnel to interact with patient ○ Maintain log of all people entering patient’s room (Healthcare workers, visitors) CDC guidance: https://www.cdc.gov/vhf/ebola/clinicians/evd/infection-control.html
Patient Care Equipment	<ul style="list-style-type: none"> ○ Preferably disposable equipment, when possible
Patient Considerations	<ul style="list-style-type: none"> ○ Non-dedicated, non-disposable equipment should be cleaned and disinfected according to manufacturer’s instructions and hospital policies ○ Limit use of needles and other sharps as much as possible ○ Avoid Aerosol generating procedures
Personal Protective Equipment	<p>For Suspect Case clinically stable; no bleeding, vomiting, or diarrhea:</p> <ul style="list-style-type: none"> ○ Single-use (disposable) fluid-resistant gown that extends to at least mid-calf or single-use (disposable) fluid-resistant coveralls without integrated hood ○ Single-use (disposable) full face shield ○ Single-use (disposable) facemask ○ Single-use (disposable) gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs CDC guidance: https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance-clinically-stable-puis.html <p>For Suspect case with bleeding, vomiting, diarrhea, or clinically unstable and/or will require invasive or aerosol-generating procedures:</p> <ul style="list-style-type: none"> ○ Impermeable garment-gown or coverall ○ Respiratory Protection – PAPR or certified N95 respirator in combination with surgical hood and full-face shield ○ Single use examination gloves with extended cuffs – two pairs should be worn ○ Single use boot covers – extend to at least mid-calf ○ Single use apron CDC guidance: https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

INSTRUCTIONS FOR SELF REPORTING SYMPTOMATIC CONTACT/TRAVELER ALREADY BEING MONITORED BY LAC DPH

- For Symptomatic Individuals:
 - Stay at home and avoid close contact with other people you live with until you are contacted by LAC DPH.
 - Stay and sleep in a separate room, if possible.
 - Use a separate bathroom, if possible.
 - Avoid close contact with any pets in the home.
 - Avoid allowing anyone who does not already live with you to come into your home.
 - Keep all trash that you physically touch (like tissues paper) in a well secured trash bag inside your room. Avoid disposing of trash, cleaning or doing laundry until LAC DPH gives approval.
 - Make plans in case you become hospitalized.
 - You can return to normal activities when LAC DPH gives approval.
 - If symptoms are life threatening, call 911 and inform of recent exposure to Ebola virus, your travel history and you are under monitoring by LAC DPH.
 - Regarding Individual's Pets at Home:
 - It is important to keep people and animals away from blood or body fluids of a person with symptoms of Ebola infection.
 - However, if a person become ill with Ebola, dogs, cats, and possibly other pets who came into contact with the patient must be assessed for exposure and may be placed in quarantine for at least 21 days following their last known exposure to the person with Ebola.

DPH INTERNAL INSTRUCTION

- Instruct HCP to immediately notify their infection control program (if available at the facility).
- Instruct HCP that ACDC will interview patient to obtain more detailed risk factor and clinical information either via phone or in person.
- Instruct HCP that ACDC will consult with CDPH and treating physician can join conference call to discuss medical evaluation.
- Instruct HCP to inform the patient to avoid posting their current medical condition/situation online or social media for their health privacy.

Internal/External Communication

- Notify appropriate ACDC staff (incl. HOBUR Unit: Moon Kim mokim@ph.lacounty.gov, Susan Hathaway shathaway@ph.lacounty.gov, Steve Moon SMoon@ph.lacounty.gov, Amy Marutani AMarutani3@ph.lacounty.gov, Dawn Terashita dterashita@ph.lacounty.gov)
- ACDC on-call suspect VHF consultation/assistance:
 - Moon Kim
 - Dawn Terashita
 - Sharon Balter