

California Department of Public Health  
 Center for Infectious Diseases  
 Division of Communicable Disease Control  
 Infectious Diseases Branch  
 Surveillance and Statistics Section  
 MS 7306, P.O. Box 997377  
 Sacramento, CA 95899-7377

Local ID Number \_\_\_\_\_

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary  Final

## VIRAL HEMORRHAGIC FEVER CASE REPORT

Check one:  Ebola  Crimean-Congo hemorrhagic fever  
 Lassa  New World arenavirus (Guanarito, Junin, Machupo, Sabia viruses)  
 Lujo  Other: \_\_\_\_\_  
 Marburg

Jurisdictions participating in CalREDIE should create a CalREDIE incident and upload the completed form to the Electronic Filing Cabinet. Jurisdictions not participating in CalREDIE should fax the completed form to (916) 552-8973. (Note: Dengue, Yellow Fever, and Hantavirus each have their own case report forms.)

PATIENT INFORMATION				
Last Name	First Name	Middle Name	Suffix	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	Ethnicity (check one) <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Unk
Address Number & Street - Residence		Apartment / Unit Number		
City / Town		State	Zip Code	
Census Tract	County of Residence	Country of Residence		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		
Home Telephone	Cellular Phone / Pager	Work / School Telephone		
E-mail Address		Other Electronic Contact Information		
Work / School Location		Work / School Contact		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____				
Medical Record Number		Patient's Parent / Guardian Name		
Occupation Setting (see list on page 7)		Other (Describe / Specify)		
Occupation (see list on page 7)		Other (Describe / Specify)		
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.				
CLINICAL INFORMATION				
Physician Name - Last Name			First Name	Telephone Number

First three letters of patient's last name:

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**SIGNS AND SYMPTOMS**

<i>Symptom Onset Date (mm/dd/yyyy)</i>				<i>Date First Sought Medical Care (mm/dd/yyyy)</i>			
Signs and Symptoms	Yes	No	Unk	Signs and Symptoms	Yes	No	Unk
Fever <i>If Yes, highest temperature (specify °F/°C): _____</i>				Abdominal pain			
Headache				Bleeding not related to injury <i>If Yes, type of bleeding</i>			
Maculopapular rash				<input type="checkbox"/> Nose bleed <input type="checkbox"/> Black or bloody stool			
Muscle pain (myalgia)				<input type="checkbox"/> Vomiting blood <input type="checkbox"/> Hemorrhagic or purpuric rash			
Joint pain				<input type="checkbox"/> Coughing up blood <input type="checkbox"/> Other: _____			
Vomiting				Pharyngitis (arenavirus only)			
Diarrhea				Retrosternal chest pain (arenavirus only)			
				<i>Other signs / symptoms (specify)</i>			

**ER / HOSPITALIZATION**

<i>Did patient visit emergency room for illness?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Was patient hospitalized?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Was patient placed in isolation?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
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*If there were any ER or hospital stays related to this illness, specify details below.*

**ER / HOSPITALIZATION - DETAILS**

<i>ER / Hospital Name 1</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>
<i>ER / Hospital Name 2</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>

**OUTCOME**

<i>Outcome?</i> <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	<i>If Survived, Survived as of _____ (mm/dd/yyyy)</i>	
	<i>If Died, Date of Death (mm/dd/yyyy)</i>	<i>Was death caused by this illness?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

First three letters of patient's last name:

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**LABORATORY INFORMATION**

**LABORATORY RESULTS SUMMARY (Please submit copies of all labs, including CBCs associated with this illness.)**

<p><i>Type of Virus Detected</i></p> <input type="checkbox"/> Ebola <input type="checkbox"/> Crimean-Congo hemorrhagic fever <input type="checkbox"/> Lassa <input type="checkbox"/> New World arenavirus (Guanarito, Junin, Machupo, Sabia viruses) <input type="checkbox"/> Lujo <input type="checkbox"/> Other: _____ <input type="checkbox"/> Marburg	<p><i>Specimen Type (check all that apply)</i></p> <input type="checkbox"/> Blood, date collected: __/__/____ <input type="checkbox"/> Tissue, date collected: __/__/____ <input type="checkbox"/> Other: _____, date collected: __/__/____
<p><i>Laboratory Name</i></p>	<p><i>Telephone Number</i></p>

Test	Result				
	Detected	Not Detected	Inconclusive	Unsatisfactory	Test Not Done
Polymerase chain reaction (PCR)					
Antigen-capture enzyme-linked immunosorbent assay (ELISA)					
IgM ELISA					
IgG ELISA					
Immunohistochemistry					
Virus isolation					
Other (specify): _____					

**ADDITIONAL LABORATORY RESULTS**

**DID THE PATIENT HAVE ANY OF THE FOLLOWING?**

Result	Yes	No	Unk	If Yes, Specify as Noted	
Leukopenia (WBC < 4,000 mm <sup>3</sup> )				Lowest WBC	
Lymphocytopenia (lymphocytes < 1,000 mm <sup>3</sup> )				Lowest lymphocytes count	
Thrombocytopenia (platelets <150,000 mm <sup>3</sup> )				Lowest platelet count	
Proteinuria					
Elevated liver AST / ALT				Highest AST	Highest ALT
Prolonged prothrombin time (PT)					
Prolonged partial thromboplastin time (PTT or aPTT)					

*Other Pathogens Isolated*

First three letters of patient's last name:

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**EPIDEMIOLOGIC INFORMATION**

**INCUBATION PERIOD: 2 TO 21 DAYS PRIOR TO ONSET OF ILLNESS**

**TRAVEL HISTORY**

Did patient travel **outside of county of residence** during the incubation period?  Yes  No  Unk

Did the patient travel **outside the U.S.** during the incubation period?  Yes  No  Unk

If Yes for either of these questions, specify all locations and dates below.

**TRAVEL HISTORY - DETAILS**

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

**EXPOSURE / RISK FACTORS**

**DID THE PATIENT EXPERIENCE ANY OF THE FOLLOWING EXPOSURES DURING THE INCUBATION PERIOD?**

Exposure	Yes	No	Unk	If Yes, Provide Additional Details or Specify as Noted
Contact with a deceased person				
Contact with a primate (e.g., monkey, chimpanzee, etc.)				
Contact with foreign arrival (e.g., visitor, immigrant, adoptee, etc.)				
Contact with blood or body fluids of a confirmed acute case of VHF (within 3 weeks of illness onset date)				Exposure Type <input type="checkbox"/> Blood <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Semen <input type="checkbox"/> Other (specify): _____
Contact with body fluids of a confirmed convalescent case of VHF (within 10 weeks of illness onset date)				Exposure Type <input type="checkbox"/> Blood <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Semen <input type="checkbox"/> Other (specify): _____
Possible occupational exposure				Occupation Type <input type="checkbox"/> Laboratory worker in a facility that handles VHF specimens <input type="checkbox"/> Laboratory worker in a facility that handles bats, rodents or primates from endemic areas <input type="checkbox"/> Healthcare worker in a facility with VHF patients <input type="checkbox"/> Other occupation: _____
Blood transfusion recipient 30 days prior to onset				Transfusion Date(s) (mm/dd/yyyy)
Organ transplant recipient 30 days prior to onset				Transplant Date(s) (mm/dd/yyyy)

In what country did exposure likely occur?

Did the patient donate blood products, organs, or tissue in the 30 days prior to symptom onset?	If Yes, specify:	Agency / Location	Type of Donation	Date(s) (mm/dd/yyyy)
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				

First three letters of patient's last name:

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**CONTACTS / OTHER ILL PERSONS**

Any contacts with similar illness (including household contacts)?  
 Yes  No  Unk If Yes, specify details below.

**ILL CONTACTS - DETAILS**

<i>Name 1</i>	<i>Age</i>	<i>Gender</i>	<i>Telephone Number</i>	<i>Type of Contact / Relationship</i>	<i>Date of Contact (mm/dd/yyyy)</i>
	<i>Street Address</i>			<i>Exposure Event</i>	<i>Illness Onset Date (mm/dd/yyyy)</i>
	<i>City</i>		<i>State</i>	<i>Zip Code</i>	<i>Date First Reported to Public Health (mm/dd/yyyy)</i>
<i>Name 2</i>	<i>Age</i>	<i>Gender</i>	<i>Telephone Number</i>	<i>Type of Contact / Relationship</i>	<i>Date of Contact (mm/dd/yyyy)</i>
	<i>Street Address</i>			<i>Exposure Event</i>	<i>Illness Onset Date (mm/dd/yyyy)</i>
	<i>City</i>		<i>State</i>	<i>Zip Code</i>	<i>Date First Reported to Public Health (mm/dd/yyyy)</i>

**NOTES / REMARKS**


**REPORTING AGENCY**

<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
<i>First Reported By</i> <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____		<i>Health education provided?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Restriction / clearance needed?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

**EPIDEMIOLOGICAL LINKAGE**

<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>
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**DISEASE CASE CLASSIFICATION**

*Case Classification (see case definition on page 6)*  
 Confirmed  Suspected  Not a case

**OUTBREAK**

*Part of known outbreak?*  Yes  No  Unk *If Yes, extent of outbreak:*  
 One CA jurisdiction  Multiple CA jurisdictions  Multistate  International  Unk  Other (specify): \_\_\_\_\_

**STATE USE ONLY**

*State Case Classification*  
 Confirmed  Suspected  Not a case  Need additional information

First three letters of  
patient's last name:

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**CASE DEFINITION****VIRAL HEMORRHAGIC FEVER (2011)****SUBTYPE(S)**

- Crimean-Congo Hemorrhagic Fever virus
- Ebola virus
- Lassa virus
- Lujo virus
- Marburg virus
- New World Arenavirus – Guanarito virus
- New World Arenavirus – Junin virus
- New World Arenavirus – Machupo virus
- New World Arenavirus – Sabia virus

**BACKGROUND**

New World Arenaviruses include: Guanarito, Machupo, Junin, Sabia viruses.

**CLINICAL CRITERIA**

An illness with acute onset with ALL of the following clinical findings:

- A fever > 40°C
- One or more of the following clinical findings:
  - Severe headache
  - Muscle pain
  - Erythematous maculopapular rash on the trunk with fine desquamation 3–4 days after rash onset
  - Vomiting
  - Diarrhea
  - Pharyngitis (arenavirus only)
  - Abdominal pain
  - Bleeding not related to injury
  - Retrosternal chest pain (arenavirus only)
  - Proteinuria (arenavirus only)
  - Thrombocytopenia

**LABORATORY CRITERIA FOR DIAGNOSIS**

One or more of the following laboratory findings:

- Detection of viral hemorrhagic fever (VHF) viral antigens in blood by enzyme-linked Immunosorbent Assay (ELISA) antigen detection
- VHF viral isolation in cell culture for blood or tissues
- Detection of VHF-specific genetic sequence by Reverse Transcription-Polymerase Chain Reaction (RT-PCR) from blood or tissues
- Detection of VHF viral antigens in tissues by immunohistochemistry

**EPIDEMIOLOGIC LINKAGE**

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

- Contact with blood or other body fluids of a patient with VHF
- Residence in—or travel to—a VHF endemic area
- Work in a laboratory that handles VHF specimens
- Work in a laboratory that handles bats, rodents, or primates from endemic areas
- Exposure to semen from a confirmed acute or convalescent case of VHF within the 10 weeks of that person's onset of symptoms

**CASE CLASSIFICATION**

**Suspected:** Case meets the clinical and epidemiologic linkage criteria.

**Confirmed:** Case meets the clinical and laboratory criteria.

**COMMENTS**

VHF refers to viral hemorrhagic fever caused by either Ebola, Lassa, Lujo, or Marburg virus, a new world arenavirus, or Crimean-Congo hemorrhagic fever.

<b>RACE DESCRIPTIONS</b>	
<b>Race</b>	<b>Description</b>
American Indian or Alaska Native	Patient has origins in <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
<b>OCCUPATION SETTING</b>	
<ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul>
<b>OCCUPATION</b>	
<ul style="list-style-type: none"> <li>• Adult film actor/actress</li> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - server</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul>	<ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - nurse</li> <li>• Medical - other/unknown</li> <li>• Military</li> <li>• Police officer</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Stay at home parent/guardian</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Volunteer</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul>