THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

UGANDA VIRAL HEMORRHAGIC FEVER CASE INVESTIGATION FORM

Send completed form and laboratory samples to:
UVRI/CDC, Attn: Viral Hemorrhagic Fever Laboratory
Plot 51-59 Nakiwogo Rd., P.O. Box 49, Entebbe, Uganda
Contact #: 0800 284384 (VHFUG) (Toll Free)

MoH/UVRI Case ID: _____

Health Facility Case ID: _____

Date of Case Report: ____/____/_____ (*dd, mm, yyyy - Example: 19 / 12 / 2018*)

Section 1. Patient Information

Patient's Surname: _____ Other Names:_____ Age: _____ ☐ Years ☐ Months
Gender: ☐ Male ☐ Female Phone Number of Patient/Family Member:_____ Owner of Phone: _____

Status of patient at time of this case report: ☐ Alive ☐ Dead *If dead,* Date of Death: ___/___/____ (*dd, mm, yyyy*)

Permanent residence:
Head of Household: _____ Village/Town: _____ Parish: _____
Sub-County: _____ District: _____ Country of Residence: _____

Occupation:
☐ Farmer ☐ Butcher ☐ Hunter/trader of game meat ☐ Miner ☐ Religious leader ☐ Housewife ☐ Pupil/student ☐ Child
☐ Businessman/woman; type of business: _____ ☐ Transporter; type of transport: _____
☐ Healthcare worker; position: _____ healthcare facility: _____ ☐ Traditional healer
☐ Other; please specify occupation: _____

Location where patient became ill:
Village/Town: _____ Sub-County: _____ District: _____
GPS Coordinates at House: latitude: _____ longitude: _____
If different from permanent residence, Dates residing at this location: ___/___/____ - ___/___/____ (*dd, mm, yyyy*)

Section 2. Clinical Signs and Symptoms

Date of initial symptom onset: ____/____/_____ (***dd, mm, yyyy***)

Please tick an answer for ALL symptoms indicating if they occurred during this illness between symptom onset and case detection:

Fever	☐ Yes	☐ No	☐ Unknown
If yes, TEMP: _____º C Source: ☐ Axillary ☐ Oral ☐ Rectal			
Vomiting/nausea	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown
Intense fatigue/general weakness	☐ Yes	☐ No	☐ Unknown
Anorexia/loss of appetite	☐ Yes	☐ No	☐ Unknown
Abdominal pain	☐ Yes	☐ No	☐ Unknown
Chest pain	☐ Yes	☐ No	☐ Unknown
Muscle pain	☐ Yes	☐ No	☐ Unknown
Joint pain	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Cough	☐ Yes	☐ No	☐ Unknown
Difficulty breathing	☐ Yes	☐ No	☐ Unknown
Difficulty swallowing	☐ Yes	☐ No	☐ Unknown
Sore throat	☐ Yes	☐ No	☐ Unknown
Jaundice (yellow eyes/gums/skin)	☐ Yes	☐ No	☐ Unknown
Conjunctivitis (red eyes)	☐ Yes	☐ No	☐ Unknown
Skin rash	☐ Yes	☐ No	☐ Unknown
Hiccups	☐ Yes	☐ No	☐ Unknown
Pain behind eyes/sensitive to light	☐ Yes	☐ No	☐ Unknown
Coma/unconscious	☐ Yes	☐ No	☐ Unknown
Confused or disoriented	☐ Yes	☐ No	☐ Unknown

Unexplained bleeding from any site	☐ Yes	☐ No	☐ Unknown
If Yes:			
Bleeding of the gums	☐ Yes	☐ No	☐ Unknown
Bleeding from injection site	☐ Yes	☐ No	☐ Unknown
Nose bleed (epistaxis)	☐ Yes	☐ No	☐ Unknown
Bloody or black stools (melena)	☐ Yes	☐ No	☐ Unknown
Blood or "coffee grounds" in vomit (hematemesis)	☐ Yes	☐ No	☐ Unknown
Coughing up blood (hemoptysis)	☐ Yes	☐ No	☐ Unknown
Bleeding from vagina, other than menstruation	☐ Yes	☐ No	☐ Unknown
Bruising of the skin (petechiae/ecchymosis)	☐ Yes	☐ No	☐ Unknown
Blood in urine (hematuria)	☐ Yes	☐ No	☐ Unknown
Other hemorrhagic symptoms	☐ Yes	☐ No	☐ Unknown
If yes, please specify: _____			

Other non-hemorrhagic clinical symptoms: ☐ Yes ☐ No ☐ Unknown
If yes, please specifiy: _____

Section 3. Hospitalization Information

At the time of this case report, is the patient hospitalized or currently being admitted to the hospital? ☐ Yes ☐ No
If yes, Date of Hospital Admission: ____/____/_____ (dd, mm, yyyy) Health Facility Name: _____
Village/Town: _____ Sub-County: _____ District: _____
Is the patient in isolation or currently being placed there? ☐ Yes ☐ No *If yes,* date of isolation: ____/____/_____ (dd, mm, yyyy)

Was the patient hospitalized or did he/she visit a health clinic previously for this illness? ☐ Yes ☐ No ☐ Unknown
If yes, please complete a line of information for each previous hospitalization:

Dates of Hospitalization	Health Facility Name	Village	District	Was the patient isolated?
___/___/____ - ___/___/____ (*dd, mm, yyyy*)				☐ Yes ☐ No
___/___/____ - ___/___/____ (*dd, mm, yyyy*)				☐ Yes ☐ No

MoH/UVRI Case ID: _____

Section 4. Epidemiological Risk Factors and Exposures

IN THE PAST ONE(1) MONTH PRIOR TO SYMPTOM ONSET:

1. Did the patient have contact with a known or suspect case, or with any sick person before becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, please complete one line of information for each sick contact:

Name of Contact	Relation to Patient	Dates of Exposure (*dd, mm, yyyy*)	Village	District	Was the person dead or alive ?	Contact Types**
		___/___/___ - ___/___/___			☐ Alive ☐ Dead, date of death: ___/___/____ (D, M, Y)	
		___/___/___ - ___/___/___			☐ Alive ☐ Dead, date of death: ___/___/____ (D, M, Y)	
		___/___/___ - ___/___/___			☐ Alive ☐ Dead, date of death: ___/___/____ (D, M, Y)	

****Contact Types: (list all that apply)**

1 – Touched the body fluids of the case (blood, vomit, saliva, urine, feces)
2 – Had direct physical contact with the body of the case (alive or dead)
3 – Touched or shared the linens, clothes, or dishes/eating utensils of the case
4 – Slept, ate, or spent time in the same household or room as the case

2. Did the patient attend a funeral before becoming ill? ☐ Yes ☐ No ☐ Unknown

If yes, please complete one line of information for each funeral attended:

Name of Deceased	Relation to Patient	Dates of Funeral Attendance (*dd, mm, yyyy*)	Village	District	Did the patient participate (carry or touch the body)?
		___/___/____ - ___/___/____			☐ Yes ☐ No ☐ Unknown
		___/___/____ - ___/___/____			☐ Yes ☐ No ☐ Unknown

3. Did the patient travel outside their home or village/town before becoming ill? ☐ Yes ☐ No ☐ Unknown

If yes, Village: _____ District: _____ Date(s): ___/___/____ - ___/___/____ (*dd, mm, yyyy*)

4. Was the patient hospitalized or did he/she go to a clinic or visit anyone in the hospital before this illness? ☐ Yes ☐ No ☐ Unk

If yes, Patient Visited: _____ Date(s): ___/___/____ - ___/___/____ (dd, mm, yyyy)

Health Facility Name: _____ Village: _____ District: _____

5. Did the patient consult a traditional/spiritual healer before becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, Name of Healer: _____Village: _____ District: _____ Date: ___/___/____ (*dd, mm, yyyy*)

6. Did the patient have direct contact (hunt, touch, eat) with animals or uncooked meat before becoming ill?

If yes, please tick relevant box(es) below: ☐ Yes ☐ No ☐ Unknown

Animal:			Status (check one only):		
☐ Bats or bat feces/urine	☐ Healthy	☐ Sick/Dead	☐ Chickens or wild birds	☐ Healthy	☐ Sick/Dead
☐ Primates (monkeys)	☐ Healthy	☐ Sick/Dead	☐ Cows, goats, or sheep	☐ Healthy	☐ Sick/Dead
☐ Rodents or rodent feces/urine	☐ Healthy	☐ Sick/Dead	☐ Other *Please specify*	☐ Healthy	☐ Sick/Dead
☐ Pigs	☐ Healthy	☐ Sick/Dead	:_____		

7. Did the patient get bitten by a tick in the past 2 weeks? ☐ Yes ☐ No ☐ Unknown

8. Did the patient skin and/or eat bush meat in the past 21 days? ☐ Yes ☐ No ☐ Unknown

Section 5. Clinical Specimens and Laboratory Testing

Sample 1:

Sample Collection Date: ____/____/_____ (*dd, mm, yyyy*)

Sample Collection Time: _ _ / _ _ (Hrs, Min) – ☐ AM ☐ PM

Sample Type:
- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Other specimen type, specify: _____

Malaria RDT: ☐ POS ☐ NEG ☐ NOT DONE

Sample 2:

Sample Collection Date: ____/____/_____ (*dd, mm, yyyy*)

Sample Collection Time: _ _ / _ _ (Hrs, Min) – ☐ AM ☐ PM

Sample Type:
- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Other specimen type, specify: _____

HIV RDT: ☐ POS ☐ NEG ☐ NOT DONE

Send specimens to:
Uganda Virus Research Institute/CDC
Attn: Viral Special Pathogens Branch,
Plot 51-59 Nakiwogo Rd., P.O. Box 49, Entebbe, Uganda
Phone: 0800 284384 (VHFUG) (Toll Free)

Specimen/shipping instructions:
- Label sample with **patient name, date of collection,** and **case ID**
- Send sample **cold** with a **cold/ice pack,** and **packaged appropriately**.
- Collect whole blood in a purple top (EDTA) tube – green or red top tubes acceptable if purple not available
- **Preferred sample volume = 4 ml** (minimum sample volume = 2ml)

Section 6. Case Investigation Form completed by:

Name: _____ Phone: _____ E-mail: _____

Position: _____ District: _____ Health Facility: _____

Information provided by: ☐ Patient ☐ Proxy; *If proxy*, Name:_____ Relation to Patient: _____