



Case Investigation Form
Ebola Virus Disease
ICD-10 Code: A98.4



Name of DRU:	Type: <input type="checkbox"/> RHU <input type="checkbox"/> CHO <input type="checkbox"/> Gov't Hospital <input type="checkbox"/> Private Hospital <input type="checkbox"/> Clinic
DRU Complete Address:	<input type="checkbox"/> Gov't Laboratory <input type="checkbox"/> Private Laboratory <input type="checkbox"/> Airport/Seaport

I. PATIENT INFORMATION

Patient Number	Patient's First Name	Middle Name	Last Name
Complete Address:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: MM / DD / YY ____/____/____	Age: _____ <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years
Patient admitted? <input type="checkbox"/> Y <input type="checkbox"/> N	Contact Nos.:	Date Admitted/Seen/Consult MM / DD / YY	MM / DD / YY
Is the patient a contact of a suspect/probable/confirmed ebola case? <input type="checkbox"/> Y <input type="checkbox"/> N			
Date of Investigation: MM / DD / YY	Name of investigator/s:	Contact Nos.:	

II. CLINICAL DATA

Fever: <input type="checkbox"/> Y <input type="checkbox"/> N Date onset: ____/____/____ Headache <input type="checkbox"/> Y <input type="checkbox"/> N Vomiting/ Nausea <input type="checkbox"/> Y <input type="checkbox"/> N Signs of Hemorrhage: Bleeding Gums <input type="checkbox"/> Y <input type="checkbox"/> N Nosebleed/ Epistaxis <input type="checkbox"/> Y <input type="checkbox"/> N Petechiae/ purpura <input type="checkbox"/> Y <input type="checkbox"/> N Red eyes/conjunctivitis: <input type="checkbox"/> Y <input type="checkbox"/> N Bloody Stool/ Melena <input type="checkbox"/> Y <input type="checkbox"/> N Hematemesis <input type="checkbox"/> Y <input type="checkbox"/> N	Other Signs/ Symptoms: Anorexia/ Loss of Appetite <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N Weakness/ Severe fatigue <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N Muscular pain <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty of Breathing <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty of Swallowing <input type="checkbox"/> Y <input type="checkbox"/> N Hiccoughs <input type="checkbox"/> Y <input type="checkbox"/> N	Are there any complications? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, specify: _____ Other symptoms: _____ Working/Final Diagnosis: _____
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III. EXPOSURE HISTORY

History of travel : N Y If YES, specify place and timing: _____ Place of travel: _____

2-7 days from onset >21 days from onset

Was there contact with a confirmed Ebola Virus Disease case 2-21 days prior to the onset of fever/ hemorrhage? Y N
 If YES, name of contact: _____ place of residence: _____ Date of contact ____/____/____

Check the type of place where exposure probably occur: Day care Barangay Home School Health Care Facility
Dormitory Others, specify _____

Are there other known cases with fever and signs of hemorrhage in the community? Y N U

IV. LABORATORY TESTS

Specimen collected (Put ✓ in the box Provided)	If YES, Date Collected	Date sent to RITM	Date received in RITM (to be filled up by RITM)	ELISA Result	PCR Result	Specify Organism	Date of Result
<input type="checkbox"/> Serum	____/____/____	____/____/____	____/____/____				____/____/____
<input type="checkbox"/> Oropharyngeal/ Nasopharyngeal swab	____/____/____	____/____/____	____/____/____				____/____/____

