HEMORRHAGIC FEVER VIRUS INFECTION
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 68

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

**NC EDSS PART 2 WIZARD**
**COMMUNICABLE DISEASE**

**IS/was patient symptomatic for this disease?** Y N U

If yes, symptom onset date (mm/dd/yyyy): ____________________________

**CHECK ALL THAT APPLY:**

- Fever
- Fatigue or malaise or weakness
- Shock
- Altered mental status
- Muscle aches/pains
- Skin rash
- Other symptoms, signs, clinical findings, or complications consistent with this illness

**Specify:**

- Thrombocytopenia
- Hemorrhagic symptoms/signs
- Other symptoms, signs, clinical findings, or complications consistent with this illness

**Restrictions to movement or freedom of action?** Y N

Check all that apply:

- Work
- Child care
- School
- Other, specify

**Date control measures issued:** ____________________________

**Date control measures ended:** ____________________________

**Date quarantine started:** ____________________________

**Date quarantine ended:** ____________________________

**Date isolation started:** ____________________________

**Date isolation ended:** ____________________________

**Did patient have a travel history during the 21 days prior to onset?** Y N U

**List travel dates and destinations:**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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**TREATMENT**

- Did the patient receive an antiviral for this illness? Y N U

**Antiviral name**

- Was antiviral prophylaxis given prior to illness onset? Y N U

**Did the patient require mechanical ventilation?** Y N U

**CLINICAL OUTCOMES**

- Survived? Y N U

- Died? Y N U

- Died from this illness? Y N U

<table>
<thead>
<tr>
<th>Date of death (mm/dd/yyyy):</th>
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**HOSPITALIZATION INFORMATION**

Was patient hospitalized for this illness >24 hours? □ Y □ N □ U

Hospital name: ____________________

City, State: ____________________

Hospital contact name: ____________________

Telephone: (_____) _______ - _______  

Admit date (mm/dd/yyyy): _____/____/____

Discharge date (mm/dd/yyyy): _____/____/____

Number of days hospitalized at time of report: ____________________

**TRAVEL/IMMIGRATION**

The patient is:

- □ Resident of NC
- □ Resident of another state or US territory
- □ Foreign Visitor
- □ Refugee
- □ Recent Immigrant
- □ Foreign Adoptee
- □ None of the above

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? □ Y □ N □ U

List persons and contact information: 

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

Additional travel/residency information:

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

**CHILD CARE/SCHOOL/COLLEGE**

Patient in child care? □ Y □ N □ U

Patient a child care worker or volunteer in child care? □ Y □ N □ U

Patient a parent or primary caregiver of a child in child care? □ Y □ N □ U

Is patient a student? □ Y □ N □ U

- Type of school: ____________________

Is patient a school WORKER / VOLUNTEER in NC school setting? □ Y □ N □ U

Give details: ______________________________________

**BEHAVIORAL RISK & CONGREGATE LIVING**

During the 21 days prior to onset of symptoms did the patient attend social gatherings or crowded settings? □ Y □ N □ U

If yes, specify:

- In what setting was the patient most likely exposed?
  - □ Restaurant
  - □ Home
  - □ Work
  - □ Child Care
  - □ School
  - □ University/College
  - □ Camp
  - □ Doctor's office/Outpatient clinic
  - □ Hospital In-patient
  - □ Hospital Emergency Department
  - □ Laboratory
  - □ Long-term care facility
  - □ Rest Home
  - □ Military
  - □ Prison/Jail/Detention Center
  - □ Place of Worship
  - □ Outdoors, including woods or wilderness
  - □ Athletics
  - □ Farm
  - □ Pool or spa
  - □ Pond, lake, river or other body of water
  - □ Hotel / motel
  - □ Social gathering, other than listed above
  - □ Travel conveyance (airplane, ship, etc.)
  - □ Travel conveyance (bus)
  - □ Travel conveyance (train)
  - □ International
  - □ Community
  - □ Other (specify)
  - □ Unknown

**ANIMAL EXPOSURE**

During the 21 days prior to onset of symptoms:

Did the patient have exposure to household pets or other animals (includes animal tissues, animal products, or animal excreta)? □ Y □ N □ U

Specifying animal:

- □ None of the above
- □ Domesticated animal (includes animal tissues, animal products, or animal excreta)
- □ Wildlife (includes animal tissues, animal products, or animal excreta)
- □ Other (specify)

Did patient work with animal importation? □ Y □ N □ U

Did the patient work at or visit a zoo, zoological park, or aquarium? □ Y □ N □ U

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? □ Y □ N □ U

Provide the nature of contact, dates, location, and other specifics for any question answered yes.

**OTHER EXPOSURE INFORMATION**

Does the patient know anyone else with similar symptoms? □ Y □ N □ U

If yes, specify:

**CASE INTERVIEWS/INVESTIGATIONS**

Was the patient interviewed? □ Y □ N □ U

Date of interview (mm/dd/yyyy): _____/____/____

Were interviews conducted with others? □ Y □ N □ U

Who was interviewed?

- □ Health care providers consulted? □ Y □ N □ U
- □ Who was consulted?
- □ Medical records reviewed (including telephone review with provider/office staff)? □ Y □ N □ U
- □ Specify reason if medical records were not reviewed:

Notes on medical record verification:

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

**GEOGRAPHICAL SITE OF EXPOSURE**

In what geographic location was the patient MOST LIKELY exposed?

- □ Specified location:
  - □ In NC
  - □ City ____________________
  - □ County ____________________
  - □ Outside NC, but within US
  - □ City ____________________
  - □ State ____________________
  - □ County ____________________
  - □ Outside US
  - □ City ____________________
  - □ Country ____________________
  - □ Unknown

Is the patient part of an outbreak of this disease? □ Y □ N

Notes:

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
Hemorrhagic Fever Virus Infection

2008 North Carolina Case Definition

Viral hemorrhagic fevers (VHFs) are caused by viruses in four distinct families: arenaviruses, filoviruses, bunyaviruses, and flaviviruses. Some of the more common viruses are recognized by disease names such as Ebola, Marburg, and Lassa, Crimean-Congo hemorrhagic and Rift-Valley fevers.

Clinical description

Signs and symptoms vary by the type of VHF. Early/prodromal manifestations often include high fever, dizziness, muscle aches, loss of strength, and exhaustion. Patients with severe cases of VHF often develop bleeding under the skin, in internal organs, or from body orifices like the mouth, eyes, or ears. However, patients rarely die from blood loss. Laboratory tests often reveal thrombocytopenia (≤100,000 platelets/mm³), hemoconcentration (i.e., hematocrit increased by ≥20%) or other evidence of plasma leakage. Severely ill patients may develop shock, delirium, seizures, coma, or multi-system organ failure.

Laboratory criteria for diagnosis

(NOTE: Laboratory confirmation represents an extreme biohazard. Viral isolation should only be attempted at CDC or another biosafety level 4 laboratory.)

- Demonstration of immunoglobulin G (IgG) or immunoglobulin M (IgM) antibody titers to one or more virus antigens in a blood or serum sample, or
- Demonstration of antigen in tissue or serum/blood samples by antigen-detection enzyme-linked immunosorbent assay (ELISA) or immunohistochemistry; detection of viral genome in blood/serum by polymerase chain reaction (PCR); or detection of virus in tissues by electron microscopy, or
- Isolation of virus from serum and/or tissue samples.

Case classification

**Suspect:** Any clinically compatible illness suspected by a health care provider of being VHF, AND having an epidemiologic link as described below.

**Probable:** A clinically compatible case that is epidemiologically linked to a confirmed case.

**Confirmed:** A clinically compatible case that is laboratory confirmed.

Criteria for epidemiologic linkage

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

- contact with blood or other body fluids- or materials contaminated with blood or body fluids- from a patient with suspected VHF,
- residence in or travel to a VHF endemic area,
- work in a laboratory that handles VHF specimens, or
- work in a laboratory that handles animals from VHF endemic areas;

OR exposure to semen from a suspected case of Ebola or Marburg VHF within the 6 weeks before onset of symptoms.