Hemorrhagic fever
Investigation form

A. Case notification

**

Case ID _____ Date of case detection _____

Health facility _____ Contact person _____

Treating physician _____ Phone _____

Form filled in by _____ Date filling the form _____

**

B. Patient identity

**

Name _____ Date of birth _____

Gender _____ Nationality _____

I residence: Country _____ **II residence**: Country _____

Governorate _____ Governorate _____

City/village _____ City/village _____

Contact details _____ Contact details _____

**

C. Patient profession

**

I occupation: Country _____ **II occupation:** Country _____

Occupation _____ Occupation _____

Institution type _____ Institution type _____

Institution name Institution name

Specific profile:

Health care _____ Hunter _____

Laboratory worker _____ Mineworker _____

**

D. Vital status

**

Status at reporting ☐ Alive ☐ Dead

If death: Date of death _____ Country of death _____

Place of death ☐ House ☐ Other: _____

Burial country _____ Burial city/village _____

**

E. Onset of signs

**

Date of onset _____ Date of fever onset _____

Country of onset _____ First symptoms _____

Fever ☐DK ☐No ☐Yes, specify: _____

Headaches ☐DK ☐No ☐Yes, specify: _____

Diarrhoea ☐DK ☐No ☐Yes, specify: _____

Stomach pain ☐DK ☐No ☐Yes, specify: _____

Vomiting ☐DK ☐No ☐Yes, specify: _____

Lethargy ☐DK ☐No ☐Yes, specify: _____

Anorexia	☐DK ☐No ☐Yes, specify:
Muscular pain	☐DK ☐No ☐Yes, specify:
Difficulty swallowing	☐DK ☐No ☐Yes, specify:
Difficulty breathing	☐DK ☐No ☐Yes, specify:
Intense coughing	☐DK ☐No ☐Yes, specify:
Skin rash	☐DK ☐No ☐Yes, specify:
Bleeding at injection	☐DK ☐No ☐Yes, specify:
Bleeding gums	☐DK ☐No ☐Yes, specify:
Conjunctival injection	☐DK ☐No ☐Yes, specify:
Dark or bloody stool	☐DK ☐No ☐Yes, specify:
Vomiting of blood	☐DK ☐No ☐Yes, specify:
Nose bleed (epistaxis)	☐DK ☐No ☐Yes, specify:
Unusual vaginal bleeding	☐DK ☐No ☐Yes, specify:
Other:	

**

F. Exposure risk in the 3 weeks preceding the onset of symptoms

**

Contact with:		*Specify name*	*Specify date of contact*
Suspected HFV	☐DK ☐No ☐Yes, specify:		
Probable HFV	☐DK ☐No ☐Yes, specify:		
Confirmed HFV	☐DK ☐No ☐Yes, specify:		
Funerals	☐DK ☐No ☐Yes, specify:		
Animals pets	☐DK ☐No ☐Yes, specify:		
Animals in zoo	☐DK ☐No ☐Yes, specify:		
Wild animals reserve	☐DK ☐No ☐Yes, specify:		
Cave/mine bats	☐DK ☐No ☐Yes, specify:		

Contact Health care:	
Admitted to hospital	☐DK ☐No ☐Yes, specify:
Visited hospital	☐DK ☐No ☐Yes, specify:
Traditional healer	☐DK ☐No ☐Yes, specify:

**

G. Medical history

**

Chronic diseases	
Infectious diseases	
Chronic treatment	
Other	

**

H. Travel to Lebanon

**

#	*Date flight*	*Company*	*From airport*	*To airport*	*Seat*	*Symptoms present*
1						
2						
3						
4						

**

I. Travel history 3 weeks before onset: outside country/city/village

**

#	*Country*	*City/village*	*Means*	*Dates*	*Visited places*
1					
2					
3					
4					

**

J. Travel history after onset

**

**

K. Case management to notification

**

#	*Health facility*	*Physician*	*Date consultation*	*Date admission*	*Date discharge*	*Infection control*	*Notes*
1							
2							
3							
4							
5							

**

L. Patient transportation

**

#	*Date*	*Mean*	*From*	*To*	*Infection control*
1					
2					
3					
4					

**

M. Specimen collection

**

#	*Type*	*Date of collection*	*Place of collection*	*Conservation*
1				
2				
3				
4				

**

N. Specimen shipment

**

Courrier _____ Ref _____

Date of packaging _____ Date of shipment _____

UN 3373 _____ Problems _____

**

O. Laboratory results

**

Ref laboratory _____ IgM _____

Date of arrival _____ PCR _____

Date of results _____ Other _____

**

P. Final classification

**

Date	*Classification*	*Notes*

**