THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

UGANDA VIRAL HEMORRHAGIC FEVER CASE INVESTIGATION FORM

Send completed form and clinical samples to:
UVRI/CDC, Attn: Viral Special Pathogens Branch
Plot 51-59 Nakiwogo Rd., P.O. Box 49, Entebbe, Uganda
Contact #: 0800 2 84384 (VHFUG) (Toll Free)

MoH/UVRI Case ID: _____

Health Facility Case ID: _____

Date of Case Report: ____/____/_____ (D, M, Yr)

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: ___/___/____ (D, M, Yr)

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

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/spiritual healer
☐ Other; please specify occupation: _____

Location Where Patient Became Ill:
Village/Town: _____ District: _____ Sub-County: _____
GPS Coordinates at House: latitude: _____ longitude: _____
If different from permanent residence, Dates residing at this location: ___/___/____ - ___/___/____ (D, M, Yr)

Section 2. Clinical Signs and Symptoms

Date of Initial Symptom Onset: ____/____/_____ **(D, M, Yr)**

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

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

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

Other non-hemorrhagic clinical symptoms: ☐ Yes ☐ No ☐ Unk
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: ____/____/_____ (D, M, Yr) Health Facility Name: _____
Village/Town: _____ District: _____ Sub-County: _____
Is the patient in isolation or currently being placed there? ☐ Yes ☐ No *If yes,* date of isolation: ____/____/_____ (D, M, Yr)

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

Dates of Hospitalization	Health Facility Name	Village	District	Was the patient isolated?
___/___/____ - ___/___/____ (D, M, Yr)				☐ Yes ☐ No
___/___/____ - ___/___/____ (D, M, Yr)				☐ 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 source case:

Name of Source Case	Relation to Patient	Dates of Exposure (D, M, Yr)	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 ☐ Unk

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

Name of Deceased Person	Relation to Patient	Dates of Funeral Attendance (D, M, Yr)	Village	District	Did the patient participate (carry or touch the body)?
		___/___/____ - ___/___/____			☐ Yes ☐ No
		___/___/____ - ___/___/____			☐ Yes ☐ No

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

If yes, Village: _____ District: _____ Date(s): ___/___/____ - ___/___/____ (D, M, Yr)

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): ___/___/____ - ___/___/____ (D, M, Yr)

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: ___/___/____ (D, M, Yr)

6. Did the patient have direct contact (hunt, touch, eat) with animals or uncooked meat before becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, please tick all that apply:

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

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

Section 5. Clinical Specimens and Laboratory Testing

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 2 84384 (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 = 4ml** (minimum sample volume = 2ml)

Has this patient had a sample submitted previously? ☐ Yes ☐ No

Sample 1: *Do not complete UVRI Only*

Sample Collection Date: ____/____/_____ (D, M, Yr)

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

Sample 2: *Do not complete UVRI Only*

Sample Collection Date: ____/____/_____ (D, M, Yr)

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

Section 6. Case Report Form Completed by:

Name: _____ Phone: _____ E-mail: _____

Position: _____ District: _____ Health Facility: _____

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

Case Name: _____ **MoH/UVRI Case ID:** _____

If the patient is deceased or has already recovered from illness, please fill out the next section.
If the patient is currently admitted to the hospital, leave the next section blank (it will be completed upon discharge)

Section 7. Patient Outcome Information

Please fill out this section at the time of patient recovery and discharge from the hospital OR at the time of patient death.

Date Outcome Information Completed: ____/____/_____ (D, M, Yr)

Final Status of the Patient: ☐ Alive ☐ Dead

Did the patient have signs of unexplained bleeding at any time during their illness? ☐ Yes ☐ No ☐ Unk
If yes, please specify: _____

If the patient has recovered and been discharged from the hospital:

Name of hospital discharged from: _____ District: _____
If the patient was isolated, Date of discharge from the isolation ward: ____/____/_____ (D, M, Yr)
Date of discharge from the hospital: ____/____/_____ (D, M, Yr)

If the patient is dead:

Date of Death: ____/____/_____ (D, M, Yr)
Place of Death: ☐ Community ☐ Hospital: _____ ☐ Other: _____
Village: _____ District: _____ Sub-County: _____

Date of Funeral/Burial: ____/____/_____ (D, M, Yr) Funeral conducted by: ☐ Family/community ☐ Outbreak burial team
Place of Funeral/Burial:
Village: _____ District: _____ Sub-County: _____

Please tick an answer for ALL symptoms indicating if they occurred at any time during this illness including during hospitalization:

Fever	☐ Yes ☐ No ☐ Unk
If yes, Temp: ____º C Source: ☐ Axillary ☐ Oral ☐ Rectal	
Vomiting/nausea	☐ Yes ☐ No ☐ Unk
Diarrhea	☐ Yes ☐ No ☐ Unk
Intense fatigue/general weakness	☐ Yes ☐ No ☐ Unk
Anorexia/loss of appetite	☐ Yes ☐ No ☐ Unk
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Chest pain	☐ Yes ☐ No ☐ Unk
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Confused or disoriented	☐ Yes ☐ No ☐ Unk

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