



## CASE INVESTIGATION FORM: VIRAL HAEMORRHAGIC FEVER (VHF)

Caused by:	<input type="checkbox"/> Marburg virus (MARV)	<input type="checkbox"/> Ebola Virus (EBOV)	<input type="checkbox"/> Another virus, name:				
<b>I. PATIENT DETAILS</b>							
Surname:		Name/s:					
Date of birth:	DD / MM / YYYY	Age:	Sex:	Male <input type="checkbox"/> Female <input type="checkbox"/>			
Contact Tel./Cell:	(000) 0000000	(000) 0000000	Occupation:				
Physical home address:							
<b>II. ATTENDING HEALTHCARE WORKER AND HEALTHCARE FACILITY DETAILS</b>							
Name of clinician:		Contact Tel./Cell clinician:	(000) 0000000				
Healthcare facility name:		Location of healthcare facility:					
Hospital case nr.:		Date of admission:	DD / MM / YYYY	Ward:			
<b>III. CLINICAL INFORMATION</b>							
<b>A. Date of onset of illness:</b>		DD / MM / YYYY					
<b>B. Clinical features</b> (Tick appropriate box: yes, no, unknown)							
Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Rash	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
If yes, specify temperature	_____ °C			If yes, date of onset?	DD / MM / YYYY		
Headache	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Trunk <input type="checkbox"/>	If yes, rash distribution?			
Muscle pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thorax <input type="checkbox"/>	Face <input type="checkbox"/>	Oral <input type="checkbox"/>	Arms <input type="checkbox"/>	All over body <input type="checkbox"/>
Joint pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Genitals <input type="checkbox"/>	Legs <input type="checkbox"/>	Soles of hands <input type="checkbox"/>	Soles of feet <input type="checkbox"/>
Abdominal pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	If yes, type of rash?			
Sore throat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Macular	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Nausea/vomiting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Maculopapular	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diarrhoea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Vesicular	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Eschar	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Petechial	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Vasculitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	If yes, type of bleeding/bruising?			
If yes, date of onset?	DD / MM / YYYY			Epistaxis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bruising	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Haematuria	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Ecchymoses	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Haematemesis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Melaena	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other, specify:							
If female, pregnant:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	n/a (male) <input type="checkbox"/>			
<b>C. Antimicrobial therapy received by patient during this illness?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>							
(If yes, complete the tables below)							
<b>Antibiotic</b>	<b>Route (po/IV/IM)</b>	<b>Date started</b>	<b>Date stopped</b>	<b>Duration of treatment (days)</b>			
		DD / MM / YYYY	DD / MM / YYYY				

**Footnotes:** \* Contact tracing should be initiated according to protocol \*\* Any immunosuppressing condition including active HIV disease

**SUBMIT COMPLETED FORM WITH SPECIMEN TO:** Special Viral Pathogens Lab, National Institute for Communicable Diseases, National Health Laboratory Service, 1 Modderfontein Road, Sandringham 2192, South Africa

**EMAIL COMPLETED FORM TO:** [jacquelinew@nicd.ac.za](mailto:jacquelinew@nicd.ac.za) / [naazneenm@nicd.ac.za](mailto:naazneenm@nicd.ac.za) / [outbreak@nicd.ac.za](mailto:outbreak@nicd.ac.za)

		DD / MM / YYYY	DD / MM / YYYY	
		DD / MM / YYYY	DD / MM / YYYY	
<b>Antimalarial</b>	<b>Route (po/IV/IM)</b>	<b>Date started</b>	<b>Date stopped</b>	<b>Duration of treatment (days)</b>
		DD / MM / YYYY	DD / MM / YYYY	
		DD / MM / YYYY	DD / MM / YYYY	
		DD / MM / YYYY	DD / MM / YYYY	

**D. Supportive management** (Tick appropriate box: yes, no, unknown)

Patient requiring intensive care support	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Patient requiring mechanical ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Patient requiring dialysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Patient requiring blood/blood product transfusion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Patient requiring other support, specify			

**IV. LABORATORY INVESTIGATION RESULTS**

Test	Result 1	Date 1	Result 2	Date 2
<b>Full blood count:</b>				
Haemoglobin		DD / MM / YYYY		DD / MM / YYYY
Platelets count		DD / MM / YYYY		DD / MM / YYYY
White cells count		DD / MM / YYYY		DD / MM / YYYY
<b>Coagulation profile</b>				
INR		DD / MM / YYYY		DD / MM / YYYY
PTT		DD / MM / YYYY		DD / MM / YYYY
D-dimers		DD / MM / YYYY		DD / MM / YYYY
<b>Liver function tests</b>				
Total bilirubin		DD / MM / YYYY		DD / MM / YYYY
Direct bilirubin		DD / MM / YYYY		DD / MM / YYYY
AST		DD / MM / YYYY		DD / MM / YYYY
ALT		DD / MM / YYYY		DD / MM / YYYY
ALP		DD / MM / YYYY		DD / MM / YYYY
GGT		DD / MM / YYYY		DD / MM / YYYY
<b>U &amp; E</b>				
Urea		DD / MM / YYYY		DD / MM / YYYY
Creatine		DD / MM / YYYY		DD / MM / YYYY
<b>Malaria tests</b>				
Malaria 1. smear 2. antigen	Positive <input type="checkbox"/> Negative <input type="checkbox"/>	DD / MM / YYYY	Positive <input type="checkbox"/> Negative <input type="checkbox"/>	DD / MM / YYYY
<b>Blood culture</b>				
DD / MM / YYYY				
<b>Other tests:</b>				
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY



<b>V RISK FACTORS/EXPOSURE HISTORY</b> (during the 3 weeks prior to illness onset)			
Travelled to a country/area where there are MVD or Ebola cases/outbreak	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Hospitalised or received medical care in a country with MVD or Ebola cases/outbreak	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
History of contact blood/bodily fluids of suspected/confirmed MVD or Ebola case	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
History of contact close environment of suspected/confirmed MVD or Ebola case	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Handled/slaughtered bats or bushmeat in a country/area with MVD or Ebola outbreak	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Handled clinical/laboratory specimens from suspected/confirmed MVD or Ebola case	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Visited caves inhabited (with Egyptian fruit bats) for mining or recreational activities	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Involved in the funeral preparations of suspected/confirmed MVD or Ebola case	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Had sex in the last 3 months with suspected/confirmed MVD or Ebola case	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
<b>VI. PAST MEDICAL AND TRAVEL HISTORY</b>			
Underlying illness**	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
If yes, give details:			
Travel outside of South Africa in the 4 weeks prior to illness onset? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
If yes, give country/ies visited:	Location/s visited within country:	Date of arrival:	Date departure:
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
Reason for travel (e.g. business, tourist, visiting friends/family), specify:			
Activities (e.g. hiking, walking, hunting) at the location, specify:			
Yellow fever vaccine received?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Antimalarial chemoprophylaxis received?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Ebola vaccine (Merck rVSV-ZEBOV) received?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
<b>List current differential diagnoses considered?</b>			

