NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

Division of Public Health Surveillance and Response and
Centre for Emerging Zoonotic and Parasitic Diseases
(NICD) 24-hour hotline number: 0800 212 552
UPDATED: 21 JAN 2025

CASE INVESTIGATION FORM: VIRAL HAEMORRAGHIC FEVER (VHF)

Caused by:	☐ Marburg virus (MARV)	☐ Ebola Virus (EBOV)	☐ Another virus, name:	

I. PATIENT DETAILS

Surname:		Name/s:			
Date of birth:	DD / MM / YYYY	Age:		Sex:	Male ☐ Female ☐
Contact Tel./Cell:	(000) 0000000	(000) 0000000		Occupation:	
Physical home address:					

II. ATTENDING HEALTHCARE WORKER AND HEALTHCARE FACILITY DETAILS

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:	

III. CLINICAL INFORMATION

A. Date of onset of illness: DD / MM / YYYY

B. Clinical features (Tick appropriate box: yes, no, unknown)

Fever	Yes ☐	No ☐	Unknown ☐	Rash	Yes ☐	No ☐	Unknown ☐
If yes, specify temperature		_____	°C	If yes, date of onset?	DD / MM / YYYY		
Headache	Yes ☐	No ☐	Trunk ☐	If yes, rash distribution?			
Muscle pain	Yes ☐	No ☐	Thorax ☐	Face ☐	Oral ☐	Arms☐	All over body ☐
Joint pain	Yes ☐	No ☐	Unknown ☐	Genitals ☐	Legs ☐	Soles of hands ☐	Soles of feet ☐
Abdominal pain	Yes ☐	No ☐	Unknown ☐	If yes, type of rash?			
Sore throat	Yes ☐	No ☐	Unknown ☐	Macular	Yes ☐	No ☐	
Nausea/vomiting	Yes ☐	No ☐	Unknown ☐	Maculopapular	Yes ☐	No ☐	
Diarrhoea	Yes ☐	No ☐	Unknown ☐	Vesicular	Yes ☐	No ☐	
Eschar	Yes ☐	No ☐	Unknown ☐	Petechial	Yes ☐	No ☐	
Jaundice	Yes ☐	No ☐	Unknown ☐	Vasculitis	Yes ☐	No ☐	
Bleeding	Yes ☐	No ☐	Unknown ☐	If yes, type of bleeding/bruising?			
If yes, date of onset?		DD / MM / YYYY		Epistaxis	Yes ☐	No ☐	
Bruising	Yes ☐	No ☐	Unknown ☐	Haematuria	Yes ☐	No ☐	
				Ecchymoses	Yes ☐	No ☐	
				Haematemisis	Yes ☐	No ☐	
				Melaena	Yes ☐	No ☐	

Other, specify:				
If female, pregnant:	Yes ☐	No ☐	Unknown ☐	n/a (male) ☐

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 / naazneenm@nicd.ac.za / outbreak@nicd.ac.za

C. **Antimicrobial therapy received by patient during this illness?** Yes ☐ No ☐ Unknown ☐
(If yes, complete the tables below)

Antibiotic	Route (po/IV/IM)	Date started	Date stopped	Duration of treatment (days)
		DD / MM / YYYY	DD / MM / YYYY	
		DD / MM / YYYY	DD / MM / YYYY	
		DD / MM / YYYY	DD / MM / YYYY	
Antimalarial	**Route (po/IV/IM)**	**Date started**	**Date stopped**	**Duration of treatment (days)**
		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 ☐	No ☐	Unknown ☐
Patient requiring mechanical ventilation	Yes ☐	No ☐	Unknown ☐
Patient requiring dialysis	Yes ☐	No ☐	Unknown ☐
Patient requiring blood/blood product transfusion	Yes ☐	No ☐	Unknown ☐
Patient requiring other support, specify			

IV. LABORATORY INVESTIGATION RESULTS

Test	Result 1	Date 1	Result 2	Date 2
Full blood count:				
Haemoglobulin		DD / MM / YYYY		DD / MM / YYYY
Platelets count		DD / MM / YYYY		DD / MM / YYYY
White cells count		DD / MM / YYYY		DD / MM / YYYY
Coagulation profile				
INR		DD / MM / YYYY		DD / MM / YYYY
PTT		DD / MM / YYYY		DD / MM / YYYY
D-dimers		DD / MM / YYYY		DD / MM / YYYY
Liver function tests				
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
U & E				
Urea		DD / MM / YYYY		DD / MM / YYYY
Creatine		DD / MM / YYYY		DD / MM / YYYY
Malaria tests				
Malaria 1. smear 2. antigen	Positive☐ Negative☐	DD / MM / YYYY	Positive☐ Negative☐	DD / MM / YYYY
Blood culture		DD / MM / YYYY		DD / MM / YYYY

Other tests:		
	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

V RISK FACTORS/EXPOSURE HISTORY (during the 3 weeks prior to illness onset)			
Travelled to a country/area where there are MVD or Ebola cases/outbreak	Yes ☐	No ☐	Unknown ☐
Hospitalised or received medical care in a country with MVD or Ebola cases/outbreak	Yes ☐	No ☐	Unknown ☐
History of contact blood/bodily fluids of suspected/confirmed MVD or Ebola case	Yes ☐	No ☐	Unknown ☐
History of contact close environment of suspected/confirmed MVD or Ebola case	Yes ☐	No ☐	Unknown ☐
Handled/slaughtered bats or bushmeat in a country/area with MVD or Ebola outbreak	Yes ☐	No ☐	Unknown ☐
Handled clinical/laboratory specimens from suspected/confirmed MVD or Ebola case	Yes ☐	No ☐	Unknown ☐
Visited caves inhabited (with Egyptian fruit bats) for mining or recreational activities	Yes ☐	No ☐	Unknown ☐
Involved in the funeral preparations of suspected/confirmed MVD or Ebola case	Yes ☐	No ☐	Unknown ☐
Had sex in the last 3 months with suspected/confirmed MVD or Ebola case	Yes ☐	No ☐	Unknown ☐

VI. PAST MEDICAL AND TRAVEL HISTORY

Underlying illness** Yes ☐ No ☐ Unknown ☐

If yes, give details:

Travel outside of South Africa in the 4 weeks prior to illness onset? Yes ☐ No ☐ Unknown ☐

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 ☐	No ☐	Unknown ☐
Antimalarial chemoprophylaxis received?	Yes ☐	No ☐	Unknown ☐
Ebola vaccine (Merck rVSV-ZEBOV) received?	Yes ☐	No ☐	Unknown ☐

List current differential diagnoses considered?