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

Centre for Emerging Zoonotic and Parasitic Diseases,
Outbreak Response Team, and Division of Public Health
Surveillance and Response
(NICD) 24-hour hotline number: 0800 212 552

CASE INVESTIGATION FORM: EBOLA VIRUS DISEASE/SUDAN VIRUS DISEASE/BUNDIBUGYO VIRUS DISEASE (EVD, SVD, BVD)

Caused by:	☐ Zaire Ebola Virus (ZEBOV)	☐ Sudan Virus (SUDV)	☐ Bundibugyo ebolavirus (BDBV)

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) ☐

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
		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 EVD/SVD or BVD cases/outbreak	Yes ☐	No ☐	Unknown ☐
Hospitalised or received medical care in a country with EVD/SVD or BVD cases/outbreak	Yes ☐	No ☐	Unknown ☐
History of contact blood/bodily fluids of suspected/confirmed EVD/SVD or BVD case	Yes ☐	No ☐	Unknown ☐
History of contact close environment of suspected/confirmed EVD/SVD or BVD case	Yes ☐	No ☐	Unknown ☐
Handled/slaughtered bats or bushmeat in a country/area with EVD/SVD or BVD outbreak	Yes ☐	No ☐	Unknown ☐
Handled clinical/laboratory specimens from suspected/confirmed EVD/SVD or BVD case	Yes ☐	No ☐	Unknown ☐
Involved in the funeral preparations of suspected/confirmed EVD/SVD or BVD case	Yes ☐	No ☐	Unknown ☐
Had sex in the last 3 months with suspected/confirmed EVD/SVD or BVD 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?

SUBMIT COMPLETED FORM WITH SPECIMEN TO: Centre for Emerging Zoonotic and Parasitic Diseases, 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 / cezd@nicd.ac.za