INVESTIGATION WORKSHEET

Defense Health Agency ®

☐ Entered in DRSi?

☐ Reported to health dept?

POC: _____

(_____) - _____ - _____

Hemorrhagic Fever, Viral

Confirmed ◯ Suspect ◯ Not a Case

STOP: Prior to filling out this form, you MUST notify Defense Centers for Public Health - Aberdeen & local Public Health Department IMMEDIATELY

DCPH-A: 410-417-2377 **Local health department: _____ - _____ - _____**

DEMOGRAPHICS

NAME: *(Last)*_____ *(First)*_____ *(MI)*_____ **PARENT/GUARDIAN:** _____

DOB: _____/_____/_____ **AGE:** _____ **FMP:** _____ **SEX:** ☐ M ☐ F ☐ Unk **RACE:** _____

UNIT: _____ **SERVICE:**_____ **RANK:** _____ **DUTY STATUS:**_____

ADDRESS: *(Street)*_____ **DoD ID:** _____

(City) _____ *(State)* _____ *(Zip)* _____ (_____) - _____ - _____ *(h)*

PHONE:

*(County)*_____ *(Country)*_____ (_____) - _____ - _____ *(c)*

CLINICAL INFORMATION

Provider: _____ **Clinic/hospital:** _____

	Y	N	
Hospitalized	☐	☐	**Admit date:** ____/_____/_____ **Discharge date:** ____/_____/_____
Deceased	☐	☐	**Date of death:** ____/_____/_____ **Cause of death:** _____

	Y	N	
Symptomatic	☐	☐	**Onset date:** ____/_____/_____ **Clinic date:** _____/_____/_____ **Diagnosis date:** _____/_____/____
Fever	☐	☐	**Max Temp:** _____°F/°C (☐ unk)
Headache	☐	☐	
Muscle pain	☐	☐	
Rash	☐	☐	
Vomiting	☐	☐	
Diarrhea	☐	☐	
Abdominal pain	☐	☐	
Pharyngitis	☐	☐	

TREATMENT

Treated with antibiotics? Y ☐ N ☐

Type of antibiotic	Date Started	Duration
1. _____	_____/_____/_____	_____
2. _____	_____/_____/_____	_____
3. _____	_____/_____/_____	_____

LABORATORY RESULTS

COMMENTS

Test (type of test performed)	Collection Date	Source (Circle Type)	Result	
☐ **Antibody**	_____/_____/_____	Serum Urine CSF Other	☐ **Positive**	☐ **Negative**
☐ **Antigen**	_____/_____/_____	Serum Urine CSF Other	☐ **Positive**	☐ **Negative**
☐ **PCR (DNA)**	_____/_____/_____	Serum Urine CSF Other	☐ **Positive**	☐ **Negative**
☐ **Culture**	_____/_____/_____	Serum Urine CSF Other	☐ **Positive**	☐ **Negative**
☐ **Screen**	_____/_____/_____	Serum Urine CSF Other	☐ **Positive**	☐ **Negative**
☐ **Other** *Describe below*	_____/_____/_____	Serum Urine CSF Other	☐ **Positive**	☐ **Negative**

TRAVEL HISTORY

In the (INCUBATION PERIOD)* before illness onset (when symptoms started), did the case.....

1. **Recently travel?** Y ☐ N ☐ Unk ☐
2. **Was travel out of country?** Y ☐ N ☐ Unk ☐
3. **Did case receive theater/ country clearance before recent out-of-country trip?** Y ☐ N ☐ Unk ☐

(If yes) **Reason for travel**

☐ Deployment
☐ TDY
☐ Vacation
☐ Visiting Friends
☐ Business (non-DoD)
☐ Other: _____

*Incubation Period: 7–21 days

Travel History (Deployment history) - Details (start with most recent travel/deployment)

Location (City, State, Country)	*# In Group (if applicable)*	*Principal reason for trip*	*Date Travel Started*	*Date Travel Ended*