World Health Organization ISARIC

# CASE RECORD FORM INSTRUCTIONS

# COMPLETE EBOLA VIRUS DISEASE DATASET

This form includes all available modules of the COMPLETE EVD DATASET. Each site can select which modules to complete based on data requirements and resource availability.

Modules included in each set of forms are:

| | |
|---|---|
| ADMISSION | **DEMOGRAPHICS** |
| | **SIGNS AND SYMPTOMS** |
| | **PATIENT INFORMATION - CASE INVESTIGATION** |
| | **EPIDEMIOLOGICAL RISK FACTORS AND EXPOSURES - CASE INVESTIGATION** |
| | **CO-MORBIDITIES** |
| | **PRE-ADMISSION MEDICATIONS** |
| | **EXPOSURE** |
| DAILY | **DAILY OBSERVATIONS & TREATMENTS** |
| | **DAILY LABORATORY RESULTS** |
| | **MEDICATIONS & BLOOD PRODUCTS** |
| | **VIRUS TESTING** |
| | **OTHER INFECTIONS** |
| | **CRITICAL CARE** |
| OUT COME | **SEVERE SYMPTOMS & COMPLICATIONS** |
| | **OUTCOME** |
| | **PATIENT OUTCOME INFORMATION - CASE INVESTIGATION** |
| | **FOLLOW-UP** |

To access and complete these forms online or print them off go to www.cliresdms.org. If you would like a copy of the database software that can be used offline on Windows-based tablets and computers contact us at isaric@oucru.org

## GENERAL GUIDANCE

- Patient numbers consist of a 3-digit site code and a 4 digit patient number. You will be assigned a site code or can obtain a site code by registering with the data manager at isaric@oucru.org. Patient numbers should be assigned sequentially for each site beginning with 0001. In the case of a single site recruiting patients on different wards, or where it is otherwise difficult to assign sequential numbers, it is acceptable to assign numbers in blocks, e.g. by ward where Out-patient ward will assign numbers from 0001 onwards. In-patient ward will assign numbers from 5001 onwards. Alpha characters can also be used. E.g. Out-patient ward will assign A001 onwards. In-patient ward will assign B001 onwards. **Please enter the unique patient identification code at the top of each and every paper sheet.**
- **Complete every line of every section**, except for where the instructions say to skip a section based on certain responses.
- Selections with circles (**O**) are single selection answers (choose one answer only). Selections with square boxes (□) are multiple selection answers (choose as many answers as are applicable).
- It is important to know when the answer to a particular question is not known. Please mark the 'Unknown' box if this is the case. For laboratory values, please enter "NA" in the data space when results are Not Available.
- We recommend writing clearly in black or blue ink, using BLOCK-CAPITAL LETTERS.
- Place an (X) when you choose the corresponding answer. To make corrections, strike through (-------) the data you wish to delete and write the correct data above it. Please initial and date all corrections.
- Please keep all of the sheets for a single patient together e.g. with a staple or in a folder that is unique to the patient.
- **Please observe your local infection control policy on record keeping and movement of records in/out of clinical areas.**

**CASE RECORD FORM – EBOLA VIRUS DISEASE**

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

## DEMOGRAPHICS

**Date:** *(DD/MM/YYYY):* [____][____]/[____][____]/[__2_][__0_][____][____]

**Surname:**____________________ **Other names:**____________________

**Clinical centre:**____________________ **Village/Town:** ____________________

**Sub-Country:** ____________________ **District:** ____________________

**Country:** ____________________

**Date of admission to this facility** *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____]

**Sex at Birth:** O Male O Female

**Date of birth**[1] *(DD/MM/YYYY):* [____][____]/[____][____]/[____][____][____][____]
OR
**Estimated age**[2] [___][___][___] O years O months *(<2 years)*

**EVD Case classification**[3]: O Laboratory-confirmed O Probable O Suspect O Unknown

**Proven malaria (by RDT or other) since onset of symptoms?** O YES O NO O Unknown

**If FEMALE: Is the patient:** O Pregnant O Gave birth within previous 6 weeks O Neither Unknown

**If PREGNANT: Gestation age of fetus** *(nearest week)*: [___][___]

**If GAVE BIRTH WITHIN 6 WEEKS: Pregnancy Outcome:** O Live birth O Still birth[4] O Termination O Spontaneous abortion/miscarriage O Unknown

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[1] Complete the known sections of day, month, year.

[2] If date of birth is unknown, state estimated age.

[3] **SUSPECTED CASE:** Any person, alive or dead, suffering or having suffered from a sudden onset of high fever and having had contact with:
- a suspected, probable or confirmed Ebola or Marburg case;
- a dead or sick animal (for Ebola)
- a mine (for Marburg)
OR: any person with sudden onset of high fever and at least three of the following symptoms:
• headaches • vomiting • anorexia / loss of appetite • diarrhoea • lethargy • stomach pain • aching muscles or joints • difficulty swallowing • breathing difficulties • hiccup
OR: any person with inexplicable bleeding
OR: any sudden, inexplicable death.
**PROBABLE CASE:** Any suspected case evaluated by a clinician
OR: Any deceased suspected case (where it has not been possible to collect specimens for laboratory confirmation) having an epidemiological link with a confirmed case
**LABORATORY CONFIRMED CASE:** Any suspected or probably cases with a positive laboratory result. Laboratory confirmed cases must test positive for the virus antigen, either by detection of virus RNA by reverse transcriptase-polymerase chain reaction (RT- PCR), or by detection of IgM antibodies directed against Marburg or Ebola.
http://www.who.int/csr/resources/publications/ebola/ebola-case-definition-contact-en.pdf?ua=1

[4] Delivery of a dead foetus ≥22 weeks gestational age determined by weeks of pregnancy at delivery, or gestational age at diagnosis of foetal death if known, or birth weight of 500 grams or more if foetal gestational age is not known.

## CASE RECORD FORM – EBOLA VIRUS DISEASE

**PATIENT IDENTIFICATION NUMBER:** [__][__][__] - [__][__][__][__]
*(3 digit site code – 4 digit sequential patient code)*

### SIGNS AND SYMPTOMS *(first available data at presentation/admission – within 24 hours):*

**Date:** *(DD/MM/YYYY):* [____][____]/[____][____]/[__2_][__0_][____][____]

**Maximum Temperature:** [___][___][___].[___]O°C *or* O°F

**Heart Rate:** [___][___][___]beats per minute **Respiratory Rate:** [___][___]breaths per minute

**Systolic Blood Pressure:** [___][___][___]mmHg **Diastolic Blood Pressure:** [___][___][___]mmHg

**Date of onset of first/earliest symptom** *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____]

**Signs and symptoms observed during this illness episode (between symptom onset and facility admission):**

| Symptom | Response | Symptom | Response |
|---|---|---|---|
| Fever | OYES ONO OUnknown | Back pain | OYES ONO OUnknown |
| Lethargy/asthenia | OYES ONO OUnknown | Chest pain | OYES ONO OUnknown |
| Headache | OYES ONO OUnknown | Sore throat | OYES ONO OUnknown |
| Joint or muscle pain/aches | OYES ONO OUnknown | Conjunctival injection[7] | OYES ONO OUnknown |
| Loss of appetite | OYES ONO OUnknown | Skin rash | OYES ONO OUnknown |
| Difficulty swallowing | OYES ONO OUnknown | Decreased urine output[8] | OYES ONO OUnknown |
| Nausea | OYES ONO OUnknown | Cough | OYES ONO OUnknown |
| Vomiting | OYES ONO OUnknown | Lower chest wall indrawing[9] | OYES ONO OUnknown |
| Diarrhoea[5] | OYES ONO OUnknown | Coma or unconscious | OYES ONO OUnknown |
| Abdominal pain | OYES ONO OUnknown | Confused/disoriented/agitated | OYES ONO OUnknown |
| Hiccups/hiccoughs | OYES ONO OUnknown | Seizures | OYES ONO OUnknown |
| Breathing difficulty | OYES ONO OUnknown | Peripheral oedema | OYES ONO OUnknown |
| Bleeding. If YES, specify: | OYES ONO OUnknown | Weak pulse | OYES ONO OUnknown |
| Epistaxis/nose | OYES ONO OUnknown | Cold extremities or pallor | OYES ONO OUnknown |
| Gingival/oral | OYES ONO OUnknown | Abdominal tenderness | OYES ONO OUnknown |
| Coughing up blood | OYES ONO OUnknown | Jaundice | OYES ONO OUnknown |
| Fresh red blood in vomit | OYES ONO OUnknown | Hepatomegaly | OYES ONO OUnknown |
| Brown blood in vomit (coffee grounds) | OYES ONO OUnknown | Splenomegaly | OYES ONO OUnknown |
| Blood in urine | OYES ONO OUnknown | Petechiae | OYES ONO OUnknown |
| Fresh red blood in stool | OYES ONO OUnknown | Bruising | OYES ONO OUnknown |
| Melaena blood in stool (tar black) | OYES ONO OUnknown | Other symptom | OYES ONO OUnknown |
| Vaginal[6] | OYES ONO OUnknown | If YES, Specify Other: | ______________________ |
| Line/venepuncture/injection site | OYES ONO OUnknown | | |
| Specify: Other haemorrhagic symptoms: | ____________________ | | |

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[5] Passage of 3 or more loose or liquid stools per day, or more frequently than is normal for the individual www.who.int/topics/diarrhoea/en/

[6] Indicate non-menstrual bleeding only

[7] Symptoms of redness in the white sclera of the eye.

[8] Less than 500 mL in 24 hours for adults.

[9] Chest moves in during inhalation (in lieu of expanding as in healthy persons) used with respiratory rate to diagnose likelihood of pneumonia in children. http://www.who.int/mediacentre/factsheets/fs331/en/

# CASE RECORD FORM – EBOLA VIRUS DISEASE

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

## PATIENT INFORMATION - CASE INVESTIGATION

**Phone Number of Patient/Family Member:**__________________________ **Owner of Phone:** ______________________________

**Permanent Residence:**

Head of Household: ________________________ Village/Town: _______________________ Parish: _________________________

Sub-County: __________________________ District: __________________________ Country of Residence: _________________

**Occupation:**

O Farmer O Butcher O Hunter/trader of game meat O Miner O Religious leader O Housewife O Pupil/student O Child

O Businessman/woman; type of business: _____________________

O Transporter; type of transport: ______________________

O Traditional healer

O Healthcare worker; position: ______________________ healthcare facility: _______________________

O Other; specify occupation: _____________________________________________________

O Unknown

**Location Where Patient Became Ill:**

Village/Town: _________________________ Sub-County: _________________________ District: _________________________

GPS Coordinates at House: latitude: __________________________ longitude: __________________________________

*If different from permanent residence,* Dates residing at this location *(DD/MM/YYYY)*:[___][___]/[___][___]/[_2_][_0_][___][___]

O Unknown

## HOSPITALIZATION INFORMATION

Is the patient in isolation or currently being placed there? O Yes O No

*If yes,* date of isolation: *(DD/MM/YYYY)*:[___][___]/[___][___]/[_2_][_0_][___][___]

**Was the patient hospitalized or did he/she visit a health clinic previously for this illness?** O YES O NO O Unknown

*If yes, please complete a line of information for each previous hospitalization*:

| **Dates of Hospitalization** *(DD/MM/YYYY)* | **Health Facility Name** | **Village** | **District** | **Was the patient isolated?** |
|---|---|---|---|---|
| __ __/__ __/20__ __ to __ __/__ __/20__ __ | | | | O YES<br>O NO<br>O Unknown |
| __ __/__ __/20__ __ to __ __/__ __/20__ __ | | | | O YES<br>O NO<br>O Unknown |

# CASE RECORD FORM – EBOLA VIRUS DISEASE

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

## EPIDEMIOLOGICAL RISK FACTORS AND EXPOSURES - CASE INVESTIGATION

***In the past ONE(1) MONTH prior to symptom onset:***

**Did the patient have contact with a known or suspect case, or with any sick person before becoming ill?** O YES O NO O Unknown

*If yes, please complete one line of information for each sick contact:*

| Name of Contact | Relation to Patient | Dates of Exposure (D, M, Yr) | Village | District | Was the person dead or alive ? (Dates: DD/MM/YYYY) | Contact Types** |
|---|---|---|---|---|---|---|
| | | __/__/__ - __/__/__ | | | O Alive<br>O Dead, date of death: __ __/__ __/20__ __ | |
| | | __/__/__ - __/__/__ | | | O Alive<br>O Dead, date of death: __ __/__ __/20__ __ | |
| | | __/__/__ - __/__/__ | | | O Alive<br>O Dead, date of death: __ __/__ __/20__ __ | |

****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

**Did the patient attend a funeral before becoming ill?** O YES O NO O Unknown

*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)? |
|---|---|---|---|---|---|
| | | __/__/___ - __/__/___ | | | O Yes O No |
| | | __/__/___ - __/__/___ | | | O Yes O No |

**Did the patient travel outside their home or village/town before becoming ill?** O YES O NO O Unknown

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

**Was the patient hospitalized or did s/he go to a clinic or visit anyone in the hospital before becoming ill?** O YES O NO O Unknown

*If yes*, Patient Visited: _________________ Date(s): ___/___/____ - ___/___/____ (D, M, Yr)

Health Facility Name: _____________________ Village: __________________ District: ____________________

**Did the patient consult a traditional/spiritual healer before becoming ill?** O YES O NO O Unknown

*If yes,* Name of Healer: __________________ Village: _____________ District: ___________ Date: ___/___/____ (D, M, Yr)

**Did the patient have direct contact (hunt, touch, eat) with animals or uncooked meat before becoming ill?** O YES O NO O Unknown

*If yes, please tick all that apply:*

| Animal: | Status (check one only): |
|---|---|
| ☐ Bats | O Healthy O Sick/Dead |
| ☐ Primates (monkeys) | O Healthy O Sick/Dead |
| ☐ Rodents | O Healthy O Sick/Dead |
| ☐ Pigs | O Healthy O Sick/Dead |
| ☐ Chickens or wild birds | O Healthy O Sick/Dead |
| ☐ Cows, goats, or sheep | O Healthy O Sick/Dead |
| ☐ Other | O Healthy O Sick/Dead *Specify:*______________________ |

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

| **CO-MORBIDITIES** *(existing PRIOR TO ADMISSION & that are active problems)* | | | |
|---|---|---|---|
| Chronic cardiac disease[10] | ○YES ○NO ○Unknown | Metastatic solid tumour[11] | ○YES ○NO ○Unknown |
| Chronic pulmonary disease[12] *(including TB, not including asthma)* | ○YES ○NO ○Unknown | Any malignancy including leukaemia & lymphoma[13] | ○YES ○NO ○Unknown |
| Physician diagnosed asthma[14] | ○YES ○NO ○Unknown | AIDS / HIV[15] | ○YES ○NO ○Unknown |
| Renal disease[16] | ○YES ○NO ○Unknown | Obese as defined by clinical staff[17] | ○YES ○NO ○Unknown |
| Moderate or severe liver disease[18] | ○YES ○NO ○Unknown | Diabetes with chronic complications[19] | ○YES ○NO ○Unknown |
| Mild liver disease[20] | ○YES ○NO ○Unknown | Rheumatologic disease | ○YES ○NO ○Unknown |
| Chronic neurological disease[21] | ○YES ○NO ○Unknown | Dementia[22] | ○YES ○NO ○Unknown |
| Hemiplegia or paraplegia[23] | ○YES ○NO ○Unknown | | |

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[10] Includes coronary heart disease, cerebrovascular disease (stroke), hypertension, peripheral artery disease, rheumatic heart disease, congenital heart disease and heart failure. www.who.int/topics/cardiovascular_diseases/en/

[11] Currently active neoplastic growth or deposit that has spread via lymph or blood to an area of the body that is remote from the primary neoplasm (tumour).

12 Chronic lung diseases that cause limitations in lung airflow (previously referred to as emphysema, chronic bronchitis), diagnosed by spirometry or clinical signs e.g. abnormal shortness of breath and increased forced expiratory time. www.who.int/respiratory/copd/diagnosis/en/

13 This refers to any known malignant neoplastic disease, including haematological malignancies, that is considered to be biologically active. It specifically does not include malignancies that have been cured or where there is no evidence of on-going disease relating to that malignancy following treatment.

[14] Recurrent attacks of breathlessness and wheezing, with varying severity and frequency www.who.int/respiratory/asthma/definition/en/

[15] laboratory-confirmed HIV-1 or HIV-2 infection (irrespective of the CD4 lymphocyte count/percentage or HIV viral load in blood), or a patient with an AIDS-defining condition.

[16] Creatinine >3mg% (265 umol/l), dialysis, transplantation, uremic syndrome

[17] BMI > 30 is obese. (BMI= weight (kg)/ square of height), abnormal fat accumulation with a risk to health. www.who.int/topics/obesity/en/

[18] Cirrhosis with PHT +/- variceal bleeding

[19] Diabetes mellitus (type I or II) with evidence of one or more complications, e.g. diabetic cardiomyopathy; nephropathy; neuropathy; retinopathy; myonecrosis; peripheral vascular disease;

[20] Cirrhosis without PHT, chronic hepatitis

[21] Disorders of the nervous system e.g. epilepsy, MS, Parkinson, chronic pain syndromes, chronic brain injuries, ALS etc.

[22] Chronic or progressive brain disease with disturbance of cortical functions; memory, thinking, orientation, comprehension, learning, language and judgement but level of consciousness is not affected. www.who.int/mental_health/neurology/

[23] Includes invasive or non-invasive mechanical ventilation, oxygenation ($O_2$) via facemask/nasal prongs/hood

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

| **PRE-ADMISSION MEDICATIONS** - **List all medications (antibiotics, antifungals, antivirals, antimalarials, analgesics, antipyretics, etc) given for this illness episode PRIOR to presentation**: *(add more pages if required)* | | | | |
|---|---|---|---|---|
| **Name of medication** *(generic name preferred)* | **Dose and frequency** | **Start date** *(DD/MM/YYYY)* | **End date** *(DD/MM/YYYY)* | **Route of administration** |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

## HEALTH WORKER EXPOSURE

**Was the patient exposed to:**

**An Ebola Treatment Centre** O YES O NO O Unknown
**Another health care facility** O YES O NO O Unknown
**A clinical laboratory** O YES O NO O Unknown
**Ebola in the community** O YES O NO O Unknown

**Exposure involved**[24]**:** O Laboratory-confirmed case O Probable case O Suspect case O Unknown

**Did exposure occur through:**

O Needle stick/sharps injury O Exposure to blood O Exposure to other bodily fluids (not blood) O Unknown exposure

O Other, Specify: _____________________________________________

**Has the patient received adequate training in PPE use?** O YES O NO O Unknown

**At the time of exposure, patient was wearing:** O No PPE O Full (national standard) PPE O Partial PPE

**If Full or Partial PPE: Was the PPE damaged in any way?** O YES O NO O Unknown

**If Partial PPE, which elements of protection were inadequate (choose all that apply):** ☐ Facial ☐ Body ☐ Hand

☐ Other, Specify: __________________________________

[24] See definitions in DEMOGRAPHICS section on first page.

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

*Complete as much as you can measure beginning one day after hospital/facility admission – information collected should reflect the previous 24 hour period. Enter minimal vital signs on Day 1, 3, 7, 14 and 28.* *UK=Unknown*

## DAILY OBSERVATIONS AND TREATMENTS *Complete all with the (most abnormal) value in the **previous 24 hours.***

| **DATE: DD/MM** **YEAR 20__ __** | __/__ | __/__ | __/__ | __/__ | __/__ | __/__ | __/__ |
|---|---|---|---|---|---|---|---|
| **Maximum Temperature** O°C *or* O°F | | | | | | | |
| **Respiratory Rate** breaths/minute | | | | | | | |
| **Heart Rate** beats/minute | | | | | | | |
| **Systolic Blood Pressure** mmHg | | | | | | | |
| **Diastolic Blood Pressure** mmHg | | | | | | | |
| **LOWEST Consciousness**[25] **A**lert, **V**erbal stimuli, **P**ainful stimuli, **U**nresponsive | A V P U | A V P U | A V P U | A V P U | A V P U | A V P U | A V P U |
| **Lethargy/asthenia?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Urine output**[26] Normal, Reduced | ONormal OReduced | ONormal OReduced | ONormal OReduced | ONormal OReduced | ONormal OReduced | ONormal OReduced | ONormal OReduced |
| **Hypovolemia?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Diarrhoea?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Vomiting/nausea?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Bleeding?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **If YES Bleeding:** *check/state all that apply* — **Epistaxis/nose?** | | | | | | | |
| **Gingival/oral?** | | | | | | | |
| **In sputum?** | | | | | | | |
| **In vomit?** | | | | | | | |
| **In urine?** | | | | | | | |
| **In stool?** | | | | | | | |
| **Vaginal?**[27] | | | | | | | |
| **Line/injection site?** | | | | | | | |
| **Other, Specify:** | | | | | | | |
| **Headache?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Conjunctival injection?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Rash?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Hiccups?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Arthralgia or myalgia?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| **Specify other signs/symptoms:** | | | | | | | |
| **Since the last assessment, patient is:** | OImproved OStable OWorse | OImproved OStable OWorse | OImproved OStable OWorse | OImproved OStable OWorse | OImproved OStable OWorse | OImproved OStable OWorse | OImproved OStable OWorse |
| **Intravenous fluids?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |
| IF YES, **IV fluid volume** Litres/24 hours | | | | | | | |
| **Oral rehydration solution?** | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK | Yes No UK |

[25] AVPU LEVEL: A is the highest and U is the lowest level - A (Patient is awake); V (Responds to verbal stimulation); P (Responds to painful stimulation); U (Completely unresponsive)

[26] Reduced = Less than 500 mL in 24 hours for adults. Normal = More than 500mL in 24 hours for adults.

[27] Indicate only non-menstrual bleeding

## CASE RECORD FORM – EBOLA VIRUS DISEASE

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

**DAILY LABORATORY RESULTS**

*Complete as much as you can measure. Critical values are listed at the top. Mark the correct unit where indicated. Use the most abnormal value per day. If Not Available enter "NA".*

| | DATE: DD/MM<br>YEAR 20__ __ | __/__ | __/__ | __/__ | __/__ | __/__ | __/__ | __/__ |
|---|---|---|---|---|---|---|---|---|
| ← MOST CRITICAL → | **Sodium**<br>mEq/L | | | | | | | |
| | **Potassium**<br>mEq/L | | | | | | | |
| | **Blood Urea Nitrogen**<br>O mmol/L *or* O mg/d | | | | | | | |
| | **Creatinine**<br>O µmol/L *or* O mg/dL | | | | | | | |
| | **Chloride**<br>mEq/L | | | | | | | |
| | **Bicarbonate**<br>mEq/L | | | | | | | |
| | **Glucose**<br>O mmol/L *or*<br>O mg/dL | | | | | | | |
| | **Lactate**<br>O mmol/L *or*<br>O mg/dL | | | | | | | |
| | **Haemoglobin**<br>O g/L *or* O g/dL | | | | | | | |
| | **Haematocrit**<br>% | | | | | | | |
| **WBC count**<br>O $x10^9$/L *or* O $x10^3$/µL | | | | | | | | |
| **Platelets**<br>O $x10^9$/L *or* O $x10^3$/µL | | | | | | | | |
| **D-dimer**<br>O ng/mL *or* O mcg/mL | | | | | | | | |
| **APTT** | | | | | | | | |
| **PT**<br>seconds | | | | | | | | |
| **INR** | | | | | | | | |
| **Amylase**<br>U/L | | | | | | | | |
| **Bilirubin**<br>O µmol/L *or* O mg/dL | | | | | | | | |
| **AST/SGOT**<br>U/L | | | | | | | | |
| **ALT/SGPT**<br>U/L | | | | | | | | |
| **Creatine kinase**<br>U/L | | | | | | | | |
| **Albumin**<br>g/dL | | | | | | | | |
| **Calcium**<br>mmol/L | | | | | | | | |

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

| **MEDICATIONS[28] & BLOOD PRODUCTS[29]:** *List all medications and blood products administered from baseline to outcome.* | | | | |
|---|---|---|---|---|
| **Blood product or Medication** *(generic name preferred)* | **Volume or Dose and frequency** *(specify or unknown)* | **Start date** *(DD/MM/YYYY)* | **End date** *(DD/MM/YYYY)* | **Route of administration** |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |
| | O unknown | __ __/__ __/20 __ __ | O On-going __ __/__ __/20 __ __ | O IV O oral O inhaled O other O unknown |

[28] **MEDICATION:** Common options include:
Antibiotics
Anti-emetics – Droperidol, Metoclopramide, Ondansetron
Anti-malarials
Anti-pyretics
Pain control – Morphine, Paracetamol, Tramadol
Tranquilisers - Chlorpromazine, Diazepam, Droperidol, Haloperidol, Phenytoin
Vitamin supplements

[29] **BLOOD PRODUCTS:** Fresh plasma, Frozen plasma, Platelets, Whole blood

**CASE RECORD FORM – EBOLA VIRUS DISEASE**

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

| **EVD TESTING:** Was EVD testing performed during this illness episode? ○YES ○NO ○Unknown **If YES, Specify below:** | | | | | |
|---|---|---|---|---|---|
| **Sample Collection Date** *(DD/MM/YYYY)* | **Local lab sample identifier (if available)** | **Sample Type** | **Method** *(one per line)* | **Test Kit Name** *(one per line)* | **Result** |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |
| __ __/__ __/20__ __ | | ○**Blood**<br>○**Other,** *Specify:*<br>________________ | ○PCR<br>○IgM ○IgG<br>○Other__________ | Specify:<br>______________ | ○Positive<br>○Negative<br>○Unknown |

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

**OTHER INFECTIONS:**
**Did the patient test positive for any other infection (include malaria if done)?** ○YES ○NO ○Unknown If YES, Specify:

| Sample/Detection Date *(DD/MM/YYYY)* | Local lab sample identifier | Sample Type | Pathogen (one per line) |
|---|---|---|---|
| ____/____/20____ | | ○**Blood** ○**Other,** *Specify:* ______________ | *Specify:* ________________________________ |
| ____/____/20____ | | ○**Blood** ○**Other,** *Specify:* ______________ | *Specify:* ________________________________ |
| ____/____/20____ | | ○**Blood** ○**Other,** *Specify:* ______________ | *Specify:* ________________________________ |
| ____/____/20____ | | ○**Blood** ○**Other,** *Specify:* ______________ | *Specify:* ________________________________ |
| ____/____/20____ | | ○**Blood** ○**Other,** *Specify:* ______________ | *Specify:* ________________________________ |
| ____/____/20____ | | ○**Blood** ○**Other,** *Specify:* ______________ | *Specify:* ________________________________ |

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

**CRITICAL CARE** *(Record the most abnormal value in the previous 24 hours)*:
**Date:** *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2_][__0_][____][____]

**Mechanical ventilation?** O YES O NO **Glasgow Coma Score**[30] *(out of 15)*: [___][___]

**$FiO_2$** *(0.21-1.0)*: [___].[___][___] or [___][___]L/min

**$PaO_2$** [___][___][___] O kPa *or* O mmHg

**Oxygen saturation**:[___][___][___]% Oxygen saturation on: O Room air O Supplemental Oxygen[31]

**Line in situ?** O YES O NO If YES: O Peripheral O Central venous O Interosseous

**Any vasopressor/inotropic support?** O YES O NO **If YES, Select support:**

| | | |
|---|---|---|
| Dopamine <5µg/kg/min OR Dobutamine OR Milrinone OR Levosimendan: | O YES | O NO |
| Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine: | O YES | O NO |
| Dopamine >15µg/k/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: | O YES | O NO |

[30] **Glasgow Coma Score (GCS):** Insert the calculated value (between 3-15) following the assessment of eye, motor and verbal responses:
Eye - Does not open eyes (1), Opens eyes in response to painful stimuli (2), Opens eyes in response to voice (3), Opens eyes spontaneously (4)
Verbal - Makes no sounds (1), Incomprehensible sounds (2), Utters inappropriate words (3), Confused, disoriented (4); Oriented, converses normally (5)
Motor - Makes no movements (1), Extension to painful stimuli (decerebrate response) (2), Abnormal flexion to painful stimuli (decorticate response) (3), Flexion / Withdrawal to painful stimuli (4), Localizes painful stimuli (5), Obeys commands (6)
31 Includes invasive or non-invasive mechanical ventilation, oxygenation ($O_2$) via facemask/nasal prongs/hood

| **PATIENT IDENTIFICATION NUMBER:** *(3 digit site code – 4 digit sequential patient code)* | [__][__][__] - [__][__][__][__] |
|---|---|

| **SEVERE SYMPTOMS & COMPLICATIONS:** **Date:** *(DD/MM/YYYY):* [____][____]/[____][____]/[__2_][__0_][____][____] | | | |
|---|---|---|---|
| **At any time during hospitalisation did the patient experience:** | | | |
| Shock[32] | ○YES ○NO ○Unknown | IV line infection | ○YES ○NO ○Unknown |
| Delirium/confusion | ○YES ○NO ○Unknown | Acute renal injury/failure | ○YES ○NO ○Unknown |
| Coma | ○YES ○NO ○Unknown | Hepatic dysfunction | ○YES ○NO ○Unknown |
| Seizure(s) | ○YES ○NO ○Unknown | Hypoglycaemia | ○YES ○NO ○Unknown |
| Pulmonary oedma | ○YES ○NO ○Unknown | Hyperkalaemia | ○YES ○NO ○Unknown |
| Bleeding | ○YES ○NO ○Unknown | Hypokalaemia | ○YES ○NO ○Unknown |
| If YES Bleeding, check all locations that apply:<br>☐ Epistaxis/nose ☐ Gingival/oral ☐ In sputum<br>☐ In vomit ☐ In stool ☐ Vaginal[33]<br>☐ Line/venepuncture/injection sites ☐ In urine<br>☐ Other, Specify: ________________________________ | | Other complication(s)<br>If YES, *Specify*:________________________________<br>________________________________<br>________________________________ | ○YES ○NO ○Unknown |

[32] Shock may be due to sepsis, intravascular volume depletion (including fluid loss and/or blood loss), myocardial dysfunction, or vasodilatation leading to poor end-organ perfusion. Cardinal features of shock include persistent hypotension, oliguria/anuria, prolonged capillary refill time, altered mental state, metabolic acidosis and sometimes cool and clammy skin. Only some of these features may be present. Hypotension may be absolute (systolic BP <90mmHg) or relative (a decrease in systolic BP >40mmHg).

[33] Indicate only non-menstrual bleeding

**PATIENT IDENTIFICATION NUMBER:** *(3 digit site code – 4 digit sequential patient code)* [__][__][__] - [__][__][__][__]

## OUTCOME *(Complete at discharge or death)*

**Final EVD diagnosis[34]:** O Laboratory-confirmed O Probable O Suspect O Non-case O Unknown

**Patient status at outcome:** O Discharged (recovered)[35] O Deceased O Transferred to another facility O Fled O Unknown

**Date of outcome selected above:** *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][____][____] O Unknown

**If DISCHARGED, Ability to self-care at discharge versus prior to illness:** O Same as prior to illness O Worse O Better O Unknown

**If TRANSFERRED, Name of new facility:** ______________________________ **Village/Town:** ______________________

**Sub-Country:** ____________________________________ **District:** ________________________________________

## PATIENT OUTCOME INFORMATION - CASE INVESTIGATION

**If DECEASED:**

**Place of death:** O Hospital O Community O Other, Specify: ______________________________________

Village: ______________________ Sub-County: ______________________ District: ________________________

**Date of Funeral/Burial:** *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][____][____] O Unknown

**Funeral conducted by:** O Family/community O Outbreak burial team

**Place of Funeral/Burial:** Village: ___________________ Sub-County: _________________ District: _________________

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34 See definitions in DEMOGRAPHICS section on first page.

35 The decision to discharge a patient should be taken on clinical grounds, but can be supported by laboratory results. A negative PCR means that the virus can't be detected anymore in the body and the patient is unlikely to be contagious. Patients can be discharged if they meet all following clinical criteria:

○ Clinical criteria:
- 3 days without fever or significant symptoms AND
- A significant improvement in clinical condition AND
- Able to feed, wash and walk independently.

○ Laboratory support:
- Antigen or PCR is negative on day 4 or later after the onset of the symptoms OR
- PCR turned negative after having been positive AND patient is clinically cured OR
- If patients suffers symptoms, but these are not thought to be due to haemorrhagic fever, 2 negative blood PCR's 48 hrs apart can be used as discharge criteria.

Note: Fever can be absent in late and terminal stages of the illness and is not a reliable sign for discharge (or admission). Absence of fever cannot be used alone to plan discharges

**PATIENT IDENTIFICATION NUMBER:**
*(3 digit site code – 4 digit sequential patient code)* **[__][__][__] - [__][__][__][__]**

## FOLLOW-UP (after discharge – include date of last contact for patients lost to follow-up.)

**Date of follow-up:** *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][____][____]

**Status at last contact:** O Alive O Deceased

**Remaining complications associated with EVD or EVD treatment?** O YES O NO O Unknown

If YES, Specify: ____________________________________________________________