

# Ebola Exposure Questionnaire for Flight Crew

Since this form is to be completed for use in the Ebola Airline Investigation at fax # 404.718.2158 after both initial interview and completion of final disposition.

**Note: If contact develops a fever  $\geq 100.4^{\circ}$  F or other symptoms of Ebola, immediately call EOC at 770.488.7100.**

Date of initial interview: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Interviewed by: \_\_\_\_\_

Interviewer's Agency: \_\_\_\_\_ Interviewer's Phone Number: \_\_\_\_\_

Interviewer's Email: \_\_\_\_\_

## Passenger Information:

1. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_ Country of Residence: \_\_\_\_\_

What are interviewee's travel plans through 21 days after potential flight exposure:

\_\_\_\_\_

Street Address for next 21 days: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone numbers for next 21 days: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Job title: \_\_\_\_\_

What flight(s) did the interviewee work or fly on with the index case: Provide complete flight information- including flight number, flight origination and destination

First flight: \_\_\_\_\_

Second flight: \_\_\_\_\_

2. Did interviewee serve in the area where the ill passenger was seated?  Yes  No

3. Did interviewee have any interactions with the index case from this flight(s)?  Yes  No

If yes, describe this event including description of the ill passenger, or their identity if known, location of the event, degree of contact (talking, touching, etc.) and length of time: \_\_\_\_\_ -

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4. Did interviewee have direct contact with blood or other body fluids (including but not limited to feces, saliva, sweat, urine, and vomit) of the index case during the flight(s) mentioned above?

Yes  No (If no, skip to question 5)

If yes, what protective equipment was worn?  Mask  Gloves  Eye Protection  Gown

Rubber boots or shoe covers  None

If yes, describe the contact including location in the plane of the body fluid and any other individuals involved: \_\_\_\_\_

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If yes, with which body fluids did interviewee come into contact? (Check all that apply)

Tears  Saliva  Respiratory secretions (cough and sneeze droplets)

Vomit  Urine  Blood  Feces  Sweat

If yes, did these fluids come in contact with the interviewee's (Read below and check all that apply):

Intact skin

Broken skin (fresh cut or scratch which bled within 24 hours before the contact; burn or abrasion that had not dried)

Mucous membrane contact (eyes, nose or mouth)

Other (Specify): \_\_\_\_\_

5. Were there any incidents during or after the flight(s) that the interviewee can recall when other individuals were in contact with the index case's blood and/or body fluids?

Yes  No

If yes, please describe situation and location in the plane:

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What protective equipment (i.e. gloves, face mask) was the interviewee wearing if he/she was involved in cleaning the cabin? (NA if not involved in cleaning)  Mask  Gloves  Eye Protection  Gown  Rubber boots or shoe covers  None

6. Did interviewee experience any symptoms (fever, body aches, abdominal pain, diarrhea, rash, sore throat, headache, vomiting, weakness, unusual bruising or bleeding) since the flight with the index case?  Yes  No (If no, skip to question 7)

If yes, which of the following symptoms did the interviewee experience since the flight with the index case, and what were the onset date and duration of symptoms (check all that apply and list onset/duration)?

|   | Symptom onset (MM/DD/YY) | Duration (in days) |
|---|--------------------------|--------------------|
| <input type="checkbox"/> Fever $\geq 100.4^\circ$ F                                 | _____                    | _____              |
| <input type="checkbox"/> Sore throat  | _____                    | _____              |
| <input type="checkbox"/> Body aches/muscle pain                                     | _____                    | _____              |
| <input type="checkbox"/> Severe headache  | _____                    | _____              |
| <input type="checkbox"/> Abdominal pain   | _____                    | _____              |
| <input type="checkbox"/> Vomiting   | _____                    | _____              |
| <input type="checkbox"/> Diarrhea   | _____                    | _____              |
| <input type="checkbox"/> Weakness   | _____                    | _____              |
| <input type="checkbox"/> Rash   | _____                    | _____              |
| Description of rash   | _____                    |                    |
| <input type="checkbox"/> Unusual bruising or bleeding (e.g., from gums, eyes, nose) | _____                    | _____              |

7. Has interviewee travelled within the last 21 days to Sierra Leone, Guinea, Liberia, or another country experiencing widespread transmission of Ebola?  Yes  No

If yes, to which countries did the interviewee travel (check all that apply)?

Sierra Leone  Guinea  Liberia  Other

If any of the above countries are selected, please notify CDC by calling EOC at 770.488.7100.

Interviewee will need to complete additional interview with CDC SME involving in-country exposure risk.

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**Classification of interviewee risk.** After the HD has completed the interview, CDC will assign a risk level and communicate follow up recommendations to the HD. **Call the EOC and ask to speak to Air Contact**

**Investigation Team after the interview to complete this process.** Refer to

<http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html> for additional information.

**Follow-up Actions (check all actions taken for this contact):**

- Active Monitoring: state or local public health authority checks with potentially exposed individual daily to assess for the presence of symptoms and fever (ie: via phone or other communication)
- Direct Active Monitoring: public health authority conducts active monitoring through direct observation
- Ebola Symptoms (fever, body aches, abdominal pain, diarrhea, rash, sore throat, severe headache, vomiting, weakness, unusual bruising or bleeding)
- Referred for medical evaluation due to presence of symptoms  
Where was (s)he referred? \_\_\_\_\_  
What was the outcome? \_\_\_\_\_  
Was (s)he tested for Ebola?  Yes  No
- Declined medical evaluation after it was recommended
- Placed under conditional release
- Placed under state issued quarantine order
- Controlled movement: exclusion from all long-distance and local public conveyances (aircraft, ship, train, bus and subway)

- Exclusion from public places (e.g., shopping centers, movie theaters), and congregate gatherings
- Exclusion from workplaces for the duration of the public health order, unless approved by the state or local health department (telework is permitted)
- Federal public health travel restrictions - [Do Not Board](http://www.cdc.gov/quarantine/quarantineisolation.html) (<http://www.cdc.gov/quarantine/quarantineisolation.html>)
- Other, please describe: \_\_\_\_\_

**Final Disposition:**

Was interviewee contacted again after the end of the 21-day incubation period?

- Yes, Date of second interview: \_\_\_\_/\_\_\_\_/\_\_\_\_  No

If yes, did interviewee develop any symptoms between the time of the flight and the end of the 21-day incubation period?  Yes  No

If yes, please specify symptoms, timing, and outcome of medical evaluation below:

|   | Symptom onset (MM/DD/YY) | Duration (in days) |
|---|--------------------------|--------------------|
| <input type="checkbox"/> Fever $\geq 100.4^{\circ}$ F | _____                    | _____              |
| <input type="checkbox"/> Sore throat                  | _____                    | _____              |
| <input type="checkbox"/> Body aches/muscle pain       | _____                    | _____              |
| <input type="checkbox"/> Severe headache              | _____                    | _____              |
| <input type="checkbox"/> Abdominal pain               | _____                    | _____              |
| <input type="checkbox"/> Vomiting                     | _____                    | _____              |
| <input type="checkbox"/> Diarrhea                     | _____                    | _____              |
| <input type="checkbox"/> Weakness                     | _____                    | _____              |

Rash \_\_\_\_\_

Description of rash \_\_\_\_\_

Unusual bruising or bleeding \_\_\_\_\_  
(e.g., from gums, eyes, nose)

Outcome of medical evaluation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Evaluating healthcare provider name/phone number: \_\_\_\_\_/(\_\_\_\_)\_\_\_\_\_