NJDOH LASSA FEVER INVESTIGATION WORKSHEET

MR #: ____________ CDRSS #: ____________

Submit with all laboratory test results via encrypted email to CDSVectorTeam@doh.nj.gov or fax to 609-826-4874.
Questions? Call 609-826-5964.

DEMOGRAPHICS

Patient Last Name	First Name	DOB:	Phone number
		____ / ____ / ____	
Address		**City**	**Municipality**

Ethnicity
Hispanic
Non-Hispanic
Unknown

Race
White Black Asian Pacific Islander American Indian or Alaskan Native
Unknown

Occupation

Industry / work setting

PHYSICIAN AND FACILITY INFORMATION

Was patient hospitalized because of this illness?

Yes No Unk

Hospital: ____

Admit: ___ / ____/ ___ Discharge: ___ / ____/ ___

Did the patient die because of this illness?

Yes No Unk

If yes, date of death: _____ / _____ / _____

Treating physician

Name:
Address:
Phone: Fax:
Email:

Hospital Laboratory Contact Information

Name:
Address:
Phone: Fax:
Email:

CLINICAL STATUS

Sign/Symptom	Response	Onset	Additional required information
Abdominal pain	Yes No Unk	___ /___ /_____	
Back pain	Yes No Unk	___ /___ /_____	
Chest pain	Yes No Unk	___ /___ /_____	
Diarrhea	Yes No Unk	___ /___ /_____	
Facial swelling	Yes No Unk	___ /___ /_____	
Fatigue	Yes No Unk	___ /___ /_____	
Fever (≥100.4°F):	Yes No Unk	___ /___ /_____	Temperature: ________°F
Headache	Yes No Unk	___ /___ /_____	
Myalgia	Yes No Unk	___ /___ /_____	
Loss of hearing	Yes No Unk	___ /___ /_____	
Shortness of breath	Yes No Unk	___ /___ /_____	
Shock	Yes No Unk	___ /___ /_____	
Unexplained hemorrhage (bleeding or bruising)	Yes No Unk	___ /___ /_____	Describe:
Vomiting	Yes No Unk	___ /___ /_____	
Weakness	Yes No Unk	___ /___ /_____	

Other symptoms/underlying medical conditions, *describe*:	
Alternate Diagnosis:	
Risk Factors (Ask all of these questions for the 21 days preceding illness onset or diagnosis) *List of areas with active Lassa transmission can be found at: https://www.cdc.gov/vhf/lassa/outbreaks/index.html*	
Was the patient in an area with active Lassa transmission? Yes No Unk	Location: Date(s):
Did patient have close contact with a sick person(s) who was recently in an area with active Lassa virus transmission? Yes No Unk	Describe contact: Date(s):
Did the patient attend a funeral in an area with active Lassa virus transmission? Yes No Unk	Location: Date(s):
Did the patient have contact with semen from a man who recovered from Lassa (through oral, vaginal or anal sex)? Yes No Unk	Specify body fluids: Date(s):
Did the patient have direct contact with blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, semen) of a person who was sick with or who died from Lassa? Yes No Unk	Describe contact: Date(s):
Did the patient have direct contact with a multimammate rat in an area with active Lassa virus transmission? Yes No Unk	Describe contact: Date(s):
Did the patient have direct contact with objects contaminated with body fluids from a person sick with Lassa or have direct contact with the body of a person who died from Lassa? Yes No Unk	Describe contact: Date(s):
Did the patient work in a laboratory where Lassa specimens were handled or in a clinical laboratory in an area with active Lass transmission? Yes No Unk	Location: Date(s):
Was the patient a caregiver for a Lassa patient or healthcare worker in an area with active Lassa transmission? Yes No Unk	Location: Date(s):
Describe other exposures and what (if any) PPE was used:	

DIAGNOSTIC TESTING

Name of Test	Performed?			Date of specimen collection	Result Positive, Equiv., Abnormal, Negative, Normal
Malaria	Yes	No	Pending	____ / ____ / ____	
Influenza	Yes	No	Pending	____ / ____ / ____	
Blood culture	Yes	No	Pending	____ / ____ / ____	
CBC	Yes	No	Pending	____ / ____ / ____	
Chemistry	Yes	No	Pending	____ / ____ / ____	
PT/INR	Yes	No	Pending	____ / ____ / ____	
Urine analysis	Yes	No	Pending	____ / ____ / ____	

Other testing, specify:

DETERMINE CONTACTS/ EXPOSURES:
Contact tracing should begin to determine household and other close contacts.

Name	*Full Address*	*Telephone #*	*Date of Birth*	*Relationship*
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	
			____ / ____ / ____	

Does patient live with any pets (e.g., dogs, cats, pigs)? Yes No Unk

Specify number and type of animal(s):

CASE NOTES