Contact name: ..... DOB: ..../..../....
First name *Surname*

Ebola virus disease exposure assessment form (long)

Public Health Unit

Name of person conducting assessment: .....

Phone number: ..... Date of assessment: ..../..../.....

Demographic information:

First name: ..... Last name: ..... DOB:..../..../..... Age:.....

Country of residence: ..... Country of birth: .....

Permanent address: .....

Temporary address: .....

Phone number: ..... Mobile: .....

Email: .....

Occupation: ..... Workplace: .....

If a healthcare worker or aid worker, what organisation did you work for? .....

What were your duties? .....

Travel information:

In the last month did you/ your child reside in or visit any country in West Africa?

Yes ☐ No ☐ Unknown ☐

1. If yes, which country or countries did you/your child visit?*

..... Arrival date: ..../..../.... Departure date: ..../..../....
..... Arrival date: ..../..../.... Departure date: ..../..../....
..... Arrival date: ..../..../.... Departure date: ..../..../....

**See CDC map for current countries where EVD is active at http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html #areas*

What was the purpose of you/your child's visit? Tourist ☐ Visit to family ☐

Healthcare worker ☐ * Other aid worker ☐ Other work (including voluntary work) ☐

**If a healthcare worker also complete – Healthcare worker assessment page 3 and PPE assessment page 5*

2. When did you/your child arrive in Australia?

Date: ..... /..... /..... Airline: ..... or Port of entry: .....

Flight no./cruise details: ..... Seat number if known: .....

Place of arrival in Australia: .....

If place of arrival not in Queensland, how did you/your child travel to Queensland?

Details (date/s of travel, airline): .....

.....

3. Have any family, household members or other travel companions visited or resided in the countries noted as above (Question 1) arrived in Australia? Yes ☐ No ☐ Unknown ☐

Do you/your child plan to travel anywhere else in the remainder of the 21 day post-exposure period? Yes ☐ Details ..... No ☐ Unknown ☐

If yes, complete separate assessment forms for each person.

Contact name: …… DOB: …./…./….
First name *Surname*

Exposure details:

Section 1 – Known contact with a person with EVD or suspected to have EVD (either dead or alive), or their immediate environment in the last 21 days	☐ **Yes – *complete Section* 1** ☐ **No – *go to Section 2***
Was the person symptomatic at the time of the contact?	☐ Yes ☐ No ☐ Unknown
Was the contact with a dead body?	☐ Yes ☐ No
Did this contact occur in a country where there is widespread EVD transmission?	☐ Yes ☐ No ☐ Unknown *If no, in what country was the contact?*……
Travelled on an aircraft or in other vehicle with a passenger known to have or suspected to have EVD?	☐ Yes ☐ No ☐ Unknown *If yes to flight, refer to EVD flight contacts flow chart.*
No direct contact with the person or body fluids, but spent time in the same room or area of a person known to have or suspected to have EVD?	☐ Yes ☐ No
Had brief contact with a person known to have or suspected to have EVD (e.g. shaking hands)?	☐ Yes ☐ No
Had close contact with person known to have or suspected to have EVD in household setting, healthcare facility or community setting? (being within two metres or in the same room or care area for prolonged period of time, brief interactions such as walking by a person or moving through a hospital does not constitute close contact)	☐ Yes ☐ No
Had direct contact or provided direct care to a person known to have or suspected to have EVD?	☐ Yes ☐ No
Had sexual contact with a person known to have or suspected to have EVD?	☐ Yes ☐ No
Direct or indirect exposure to blood or body fluids (including faeces, saliva, sweat, urine, vomit or semen) of a person known to have or suspected to have EVD including percutaneous (needle stick injury) or mucous membrane exposure?	☐ Yes –*specify* …… …… …… ☐ No ☐ Unknown
During this contact did you use any PPE?	☐ Yes – *assess using PPE assessment page 5* ☐ No ☐ Unknown
Section 2 – No known contact with person known to have or suspected to have EVD, but has been in country or area with ongoing, intense EVD transmission in the last 21 days	☐ **Yes** ☐ **No** ☐ **Unknown**
Did you handle bats or primates in an area where EVD is present?	☐ Yes ☐ No
Did you hunt or prepare 'bushmeat'?	☐ Yes ☐ No
Did you have contact with blood or body fluids of animals either alive or dead while in the country? (this does not include commercially prepared meat)	☐ Yes ☐ No
Did you participate in funeral rites of a person?	☐ Yes ☐ No
Were you admitted to or attended any hospital or healthcare facility?	☐ Yes ☐ No

If yes to any of the above, describe and document date/s: ……

……

……

Contact name: …… DOB: …./…./….
First name *Surname*

Clinical information:

If the person is still within the 21-day period after last exposure, ask detailed questions regarding symptoms:

Fever: Yes ☐ ……°C	Not measured ☐	No ☐	Date ….. /….. /…..
Fatigue	Yes ☐	No ☐	Date ….. /….. /…..
Myalgia	Yes ☐	No ☐	Date ….. /….. /…..
Severe headache	Yes ☐	No ☐	Date ….. /….. /…..
Conjunctival injection	Yes ☐	No ☐	Date ….. /….. /…..
Hiccup	Yes ☐	No ☐	Date ….. /….. /…..
Influenza-like illness	Yes ☐	No ☐	Date ….. /….. /…..
Vomiting	Yes ☐	No ☐	Date ….. /….. /…..
Diarrhoea	Yes ☐	No ☐	Date ….. /….. /…..
Abdominal pain	Yes ☐	No ☐	Date ….. /….. /…..
Rash	Yes ☐	No ☐	Date ….. /….. /…..
Unexplained haemorrhage	Yes ☐	No ☐	Date ….. /….. /…..
Other	Yes ☐	No ☐	Date ….. /….. /…..

If yes, specify: ……

Date of first medical consultation: ….. /….. /….. Facility visited: ……

Facility contact person and phone number: ……

If not a healthcare worker proceed to Risk assessment categorisation and Management on page 6

Healthcare worker assessment:

1. What organisation did you work for? ……
2. Organisation contact person and details: ……

   ……
3. What were your duties? ……
4. Calculate the incubation period

Last contact with known Ebola case, or their enviroment Date: …./…./….

Or

Departure from West African country Date: …./…./…. + 21 days = Date: …./…./….

Contact name: …… DOB: …./…./….
First name *Surname*

Possible risk factors for Ebola transmission in healthcare setting in the last 21 days:

Section 1 – Medical/nursing/paramedic giving direct care to an EVD patient	☐ **Yes – *complete Section 1*** ☐ **No – *go to Section 2***
Wearing PPE during all direct contact with a person known to have or suspected to have EVD, or their enviroment?	☐ Yes ☐ No ☐ Unsure *If yes, assess using PPE assessment page 5*
Had blood or body fluid splash to mucous membrane from a suspected or confirmed EVD case?	☐ Yes ☐ No ☐ Unsure
Had a needle stick injury from a suspected or confirmed EVD case	☐ Yes ☐ No ☐ Unsure
Had potential droplet exposure to person with EVD where the person had vomiting/diarrhoea/coughing, or during an aerosol generating procedure?	☐ Yes ☐ No ☐ Unsure
Section 2 – Other duties in healthcare setting	☐ **Yes – *complete Section 2*** ☐ **No**
Worked in a laboratory where blood or body fluid samples from a suspected or confirmed case were processed while wearing PPE?	☐ Yes ☐ No ☐ Unsure *If yes, assess using PPE assessment page 5*
Domestic duties – cleaning patient area including bathroom used by patient known to have or suspected to have EVD?	☐ Yes ☐ No ☐ Unsure *When yes- assess using PPE assessment page 5*
Administrative/office duties in ward of patient known to have or suspected to have EVD, where patient was not appropriately isolated?	☐ Yes ☐ No ☐ Unsure
Had direct brief contact with patient known to have or suspected to have EVD (e.g. shaking hands)?	☐ Yes ☐ No ☐ Unsure
Had any potential contact with the environment of the patient known to have or suspected to have EVD	☐ Yes ☐ No ☐ Unsure
Had been in the same room, within two metres of patient known to have or suspected to have EVD?	☐ Yes ☐ No ☐ Unsure
Wearing PPE during all contact/s with person known to have or suspected to have EVD, including contact with their body fluids or environment?	☐ Yes ☐ No ☐ Unsure *If yes, assess using PPE assessment page 5*

If yes to any of the above exposures, describe and document date/s: ……

……

……

……

……

Contact name: …… DOB: …./…./….
First name *Surname*

PPE assessment:

Specific item of PPE (items recommended by Queensland Health)		**Details**
Gloves 2 pairs long cuff gloves	☐ Yes ☐ No ☐ Sometimes	
Long sleeved fluid resistant or impermeable gown that extends to at least mid-calf or coverall	☐ Yes ☐ No ☐ Sometimes	
Eye protection	☐ Yes ☐ No ☐ Sometimes	
Surgical hood which extends to shoulders if using gown or coverall without head cover	☐ Yes ☐ No ☐ Sometimes	
P2N95 respirator mask	☐ Yes ☐ No ☐ Sometimes	
Full length face shield	☐ Yes ☐ No ☐ Sometimes	
Leg and shoe covers-fluid resistant or impermeable boot covers that extend to at least mid-calf or gumboots under the gown or coverall	☐ Yes ☐ No ☐ Sometimes	
Coverall- used with P2/N95 respirator, full-length face shield, two pairs of non-sterile long cuff gloves, coverall that includes head covering, shoe covers	☐ Yes ☐ No ☐ Sometimes	
Did you have a 'trained observer' with you when you were donning and removing all of your PPE items?	☐ Yes ☐ No ☐ Sometimes	*If yes, was the process advised step by step?*
Was there a written process available for you to follow in donning and removing your PPE?	☐ Yes ☐ No Unsure ☐	*If yes, was the process documented*?
Were you trained in donning and removing of PPE (including fit-tested for P2/N95 mask)?	☐ Yes ☐ No	*If yes, did you feel competent in the process?*
Were you concerned about any part of the process in donning and removing your PPE or about any potential breach in the PPE?	☐ Yes ☐ No	
Where did you remove your PPE?	*Specify*	
How was the PPE disposed?	*Specify*	
After removing PPE did you wash your hands and have a shower?	☐ Yes ☐ No ☐ Sometimes	
When did you provide care to a patient known to have or suspected to have EVD?	*List all dates, if known*	

Contact name: ..... DOB: ..../..../....
First name *Surname*

Risk assessment categorisation:

Symptoms consistent with EVD infection	**Epidemiological evidence of exposure**	**Level of exposure***	**Assessment**
Yes ☐ No ☐	Yes ☐ No ☐	High ☐ Low ☐ Casual ☐ No risk ☐	Suspected EVD case ☐ Low/high risk exposure for voluntary home restriction ☐ Self-Monitoring ☐

*refer to the **Queensland Ebola virus disease management plan** available at http://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/diseases/ebola/default.asp

Monitoring by:

Contact (self-monitoring) ☐ PHU ☐ 13 HEALTH (13 43 25 84) ☐

Do you have a thermometer? Yes ☐ No ☐ If no, PHU to supply

Management:
Suspected EVD case ☐
Voluntary home restriction (VHR) Yes ☐* No ☐
*Refer to *Interim guidelines for Ebola virus disease voluntary home restriction for details*, available at www.health.qld.gov.au/ebola

Initial arrangements for voluntary home restriction:

☐ Accommodation and safety: .....
☐ Supply of food: .....
☐ Other people in the house: .....
☐ Ability to communicate via phone and internet: .....
☐ Address: .....
☐ Contact number: .....

First date in home restriction: ...../...../.....
Last date in home restriction: ...../...../.....

Outcome of monitoring/restriction:

☐ Cleared on Date: ..../..../.... at ..... (as no symptoms 21 days after last exposure)

☐ Tested positive EVD Date: ..../..../....
Comments and summary of findings:

.....

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