

EBOLA VIRUS DISEASE EXPOSURE RISK EVALUATION (IN THEATER USE ONLY)

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The public reporting burden for this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 222350-3100 (0720-0056). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ADDRESS.**

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting the personal information requested by this form and how it may be used.

AUTHORITY: 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; 42 U.S.C. 264-272, Quarantine and Inspection, Executive Order 13295, Revised List of Quarantinable Communicable Diseases; 42 CFR Part 70, Interstate Quarantine; 42 CFR Part 71, Foreign Quarantine; DoDI 6490.03, Deployment Health; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): Your information may be used for the purpose of collecting certain communicable disease(s) data IAW regulations providing for the apprehension, detention, or conditional release of individuals to prevent the introduction, transmission, or spread of suspected communicable diseases, pursuant to section 361(b) of the Public Health Service Act. Your information will be collected in order to identify any health concerns and, if necessary, refer you for additional assessment and/or care.

ROUTINE USE(S): Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at: <http://dpclid.defense.gov/privacy/SORNSIndex/BlanketRoutineUses.aspx> and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, healthcare operations, and the containment of certain communicable diseases.

DISCLOSURE: Mandatory. To protect the health of the public from Ebola, a highly infectious virus of significant public health threat, you are hereby required to provide the requested information. Care will not be denied if you decline to provide the requested information, but you may not receive the care you deserve and may face administrative delays.

INSTRUCTIONS: DoD personnel must **IMMEDIATELY report any potential Ebola Virus Disease [EVD] exposure while deployed in an Ebola outbreak country or region. Prompt medical evaluation is critical.** You are required to truthfully answer all questions. Failure to disclose the requested medical information regarding potential EVD contact or exposure risks while deployed to an Ebola outbreak area may result in UCMJ and/or criminal punishment. If you do not understand a question, please discuss the question with a healthcare provider.

DEMOGRAPHICS

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: _____ Today's Date (dd/mmm/yyyy): _____

Date of Birth (dd/mmm/yyyy): _____ Gender: Male Female

Service Branch:	Component:	Pay Grade:		
<input type="radio"/> Air Force	<input type="radio"/> Active Duty	<input type="radio"/> E1	<input type="radio"/> O1	<input type="radio"/> W1
<input type="radio"/> Army	<input type="radio"/> National Guard	<input type="radio"/> E2	<input type="radio"/> O2	<input type="radio"/> W2
<input type="radio"/> Navy	<input type="radio"/> Reserves	<input type="radio"/> E3	<input type="radio"/> O3	<input type="radio"/> W3
<input type="radio"/> Marine Corps	<input type="radio"/> Civilian Government Employee	<input type="radio"/> E4	<input type="radio"/> O4	<input type="radio"/> W4
<input type="radio"/> Coast Guard	<input type="radio"/> Contractor	<input type="radio"/> E5	<input type="radio"/> O5	<input type="radio"/> W5
<input type="radio"/> Civilian Expeditionary Workforce		<input type="radio"/> E6	<input type="radio"/> O6	
<input type="radio"/> USPHS		<input type="radio"/> E7	<input type="radio"/> O7	
<input type="radio"/> Other Defense Agency (List): _____		<input type="radio"/> E8	<input type="radio"/> O8	<input type="radio"/> Other
<input type="radio"/> Other (List): _____		<input type="radio"/> E9	<input type="radio"/> O9	
			<input type="radio"/> O10	

Home Station/Unit: _____

Current Contact Information:	Point of contact who can always reach you:
Phone: _____	Name: _____
Cell: _____	Phone: _____
DSN: _____	Email: _____
Email: _____	Address: _____

Address: _____

Deployment location(s): Liberia Sierra Leone Guinea Senegal Nigeria Other: _____

Deployed Station/Unit: _____ Duties while deployed: _____

Date arrived in theater (dd/mmm/yyyy): _____

EBOLA VIRUS DISEASE EXPOSURE RISK EVALUATION (IN THEATER USE ONLY)

Deployer's SSN (Last 4 digits): _____

COMPLETED BY DESIGNATED MEDICAL PROVIDER ONLY – Provider Review, Interview, Exposure Risk Evaluation

PART I - A : Ebola Virus Disease Risk Assessment [Mark all that apply. If "Yes" document date, time & type of MOST recent exposure.]

SOME RISK OF EXPOSURE: One or more of the following within the past 21 days.		Yes	No
1.	<p>Close contact with an Ebola Virus Disease (EVD) patient in any of the following settings: household, living quarters, work, or community? If yes, document date, time and type of contact and/or exposure.</p> <p style="margin-left: 20px;">Date (dd/mmm/yyyy): _____ Time: _____ Type: _____</p> <p>Close contact is defined as:</p> <p>a. Being within approximately 3 feet (1 meter) of an EVD patient for a prolonged period of time while not wearing recommended personal protective equipment (PPE) or PPE was compromised.</p> <p>b. Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment (PPE) or PPE was compromised.</p> <p>(Brief interactions, such as walking by a person, do not constitute close contact.)</p>	<input type="radio"/>	<input type="radio"/>
2.	<p>Other close contact with EVD patients in healthcare facilities or community settings? If yes, document date, time and type of contact and/or exposure.</p> <p style="margin-left: 20px;">Date (dd/mmm/yyyy): _____ Time: _____ Type: _____</p> <p>Close contact is defined as:</p> <p>a. Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (PPE) (standard droplet and contact precautions) or PPE was compromised.</p> <p>b. Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment (PPE) or PPE was compromised.</p> <p>(Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.)</p>	<input type="radio"/>	<input type="radio"/>
HIGH RISK OF EXPOSURE: One or more of the following within the past 21 days.		Yes	No
3.	<p>Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of an EVD patient? If yes, document date, time and type of contact and/or exposure.</p> <p style="margin-left: 20px;">Date (dd/mmm/yyyy): _____ Time: _____ Type: _____</p>	<input type="radio"/>	<input type="radio"/>
4.	<p>Direct skin contact with, or exposed to, blood or body fluids of an EVD patient without appropriate personal protective equipment (PPE) or PPE was compromised? If yes, document date, time and type of contact and/or exposure.</p> <p style="margin-left: 20px;">Date (dd/mmm/yyyy): _____ Time: _____ Type: _____</p>	<input type="radio"/>	<input type="radio"/>
5.	<p>Processing blood or body fluids of a confirmed EVD patient without appropriate personal protective equipment (PPE), standard biosafety precautions or PPE was compromised? If yes, document date, time and type of contact and/or exposure.</p> <p style="margin-left: 20px;">Date (dd/mmm/yyyy): _____ Time: _____ Type: _____</p>	<input type="radio"/>	<input type="radio"/>
6.	<p>Direct contact with a dead body without appropriate personal protective equipment (PPE), or PPE was compromised in a country where an EVD outbreak is occurring? If yes, document date, time and type of contact and/or exposure.</p> <p style="margin-left: 20px;">Date (dd/mmm/yyyy): _____ Time: _____ Type: _____</p>	<input type="radio"/>	<input type="radio"/>

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Deployer's SSN (Last 4 digits): _____

PART I -B: Ebola Virus Disease Clinical Evaluation [Mark all that apply.]

1.	Ask "Are you currently experiencing any of the following signs and symptoms?"	Yes	No
	a. Fever (temperature of > 100.4°F) <input type="radio"/> Don't Know	<input type="radio"/>	<input type="radio"/>
	b. Subjective fever (e.g., chills, night sweats)	<input type="radio"/>	<input type="radio"/>
	c. Severe headache	<input type="radio"/>	<input type="radio"/>
	d. Joint and muscle aches	<input type="radio"/>	<input type="radio"/>
	e. Abdominal/stomach pain	<input type="radio"/>	<input type="radio"/>
	f. Vomiting	<input type="radio"/>	<input type="radio"/>
	g. Diarrhea	<input type="radio"/>	<input type="radio"/>
	h. Unexplained bruising or bleeding	<input type="radio"/>	<input type="radio"/>
	i. New skin rash	<input type="radio"/>	<input type="radio"/>
	j. Other (describe in block #5)	<input type="radio"/>	<input type="radio"/>

2. Ask "Have you taken any fever-reducing medications within the past twelve [12] hours?"
(e.g., aspirin, Tylenol, Motrin, Ibuprofen) Yes No

3. Conduct and record temperature check.
Temperature: _____ Time: _____

4. Date and time of onset of symptoms. Date(dd/mmm/yyyy): _____ Time: _____ N/A

5. Comments:

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Deployer's SSN (Last 4 digits): _____

PART I-C: Ebola Virus Disease Risk Category [Mark ONLY one.]

Disposition Guidance: Document risk category in the individual's medical record.

<input type="radio"/> No Known Exposure	<p>Asymptomatic:</p> <ul style="list-style-type: none"> Return to duty and continue twice daily unit monitoring for exposure risk and clinical symptoms. <p>Symptomatic (Fever WITH or WITHOUT other symptoms)</p> <ul style="list-style-type: none"> Evaluation by medical authority. Implement infection control precautions.
<input type="radio"/> Some Risk of Exposure ("Yes" to questions 1 or 2, PART I-A)	<p>Asymptomatic:</p> <ul style="list-style-type: none"> Evaluate for potential medical evacuation IAW official policy. If determined to be "minimal risk" return to duty and begin twice daily monitoring by medical authorities for 21 days. <p>Symptomatic: (Fever WITH or WITHOUT other symptoms)</p> <ul style="list-style-type: none"> Evaluation by medical authority. Isolate and separate from "High Risk individuals. Implement infection control precautions. Evacuate from theater via regulated movement to a DoD designated medical facility capable of providing care for EVD patients IAW official policy.
<input type="radio"/> High Risk Exposure ("Yes" to questions 3, 4, 5, or 6, PART I-A)	<p>Asymptomatic:</p> <ul style="list-style-type: none"> Evaluation by medical authorities. Quarantine and evacuate from theater via regulated movement to a DoD designated facility capable of monitoring for signs and symptoms and providing care for EVD patients IAW official policy. <p>Symptomatic: (Fever or other symptoms)</p> <ul style="list-style-type: none"> Evaluation by medical authorities. Isolate and separate from "Some Risk" individuals. Implement infection control precautions. Evacuate from theater via regulated movement to a DoD designated facility capable of providing care for EVD patients IAW official policy.

Provider's Name: _____ Date (dd/mmm/yyyy): _____ Time: _____

Title: MD DO PA Nurse Practitioner Adv Practice Nurse Other: _____

I certify this assessment process has been completed. Provider's Signature: _____