

## ANNEX 2

### 2.1. Primary Screening Form- Template/Example

Instructions:

- The form should be completed at the venue by meeting participants, if they develop any of the symptoms listed below.
- The forms should be given to and validated by public health staff at the meeting.
- Countries with Ebola virus disease (EVD) transmission include Guinea, Liberia and Sierra Leone.

1. Last name: \_\_\_\_\_ First name: \_\_\_\_\_

2. Sex: \_\_\_\_\_ Date of birth: \_\_/\_\_/\_\_

3. Participant Contact (Hotel, group, Tel/Email address):

\_\_\_\_\_

Symptoms	Yes	No	Unknown
Fever			
Vomiting			
Joint pain			
Weakness			
Blood from nose or mouth, in vomit or stool, dark or bloody urine			
When did the first symptoms start? (DD/MM/YYYY)			
<b>ONLY APPLICABLE FOR PARTICIPANTS</b> with history of travel to EVD-affected countries			
History of contact with someone who has been sick with vomiting, diarrhoea, or bleeding in the previous 3 weeks?			
History of contact with someone who died in the previous 3 weeks?			
History of participation in a funeral in the previous 3 weeks?			

Geographic origin	
Country of residence:	
Travelling from:	
Travelling to:	

## 2.2. Secondary Screening Form- Template/Example

### **PUBLIC HEALTH INTERVIEW: SECONDARY SCREENING**

Date of interview: \_\_\_\_/\_\_\_\_/\_\_\_\_ Venue ID: \_\_\_\_\_

ID/Passport No: \_\_\_\_\_

#### **Meeting Participant Details**

Surname: \_\_\_\_\_

Name(s): \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age (years): \_\_\_\_\_ Sex: ☐ M ☐ F

Place/Hotel where participant stayed: \_\_\_\_\_

Nationality: \_\_\_\_\_

Profession: \_\_\_\_\_

#### **Participant's condition**

Current condition: ☐ Ambulatory ☐ Non Ambulatory

#### **History**

Does the participant show any of the following symptoms? (tick all applicable)

Has the participant had a fever? ☐ Yes ☐ No ☐ Unknown

Date of onset of symptoms (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

SYMPTOMS	YES	NO	UNKNOWN
Headaches			
Diarrhoea			
Sore throat			
Stomach pain			
Vomiting			
Lethargy			
Anorexia			
Muscular pain			
Difficulty breathing			
Difficulty swallowing			
Intense coughing			
Hiccups			
Skin rash			
Bleeding at injection points			
Bleeding gums (gingivitis)			
Bleeding in eye (conjunctival infection)			
Dark or bloody stool (melena)			
Nosebleed (epistaxis)			
Vomiting of blood (haematemesis)			
Vaginal bleeding outside of menstruation			

**Laboratory**

Have laboratory samples been taken?

☐ Yes      ☐ No**Exposure risk**

EXPOSURE RISK	YES	NO	DON'T KNOW
Has the patient been in contact with a <b>suspected or confirmed case</b> in the 3 weeks preceding the onset of the symptoms?			
Was the patient <b>hospitalized</b> or has he/she visited a hospitalized person in the 3 weeks preceding the onset of the symptoms?			
Has the patient consulted a <b>health worker/traditional healer</b> in the 3 weeks preceding the onset of the symptoms?			
Has the patient attended any <b>funerals</b> in the 3 weeks preceding the onset of the symptoms?			
Has the patient had contact with any wild <b>animals</b> in the 3 weeks preceding the onset of the symptoms?			

Final case classification (tick the appropriate box)					
<input type="checkbox"/> Suspected	<input type="checkbox"/> Probable	<input type="checkbox"/> Confirmed	<input type="checkbox"/> No case	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Others