Suspect Ebola Patient Screening Tool for Sacramento County Response

Date: ______________________ Time: ______________________

Patient Name: ____

Patient Address ____

Insurance Plan and # for billing purposes: ______________________
I.D. ____

Referring institution: ____

Name of person calling: ____

Is this patient a known traveler under surveillance? Yes No

If no, what is their travel history in the past 30 days with dates?

____

____

If visited West Africa, list itinerary and travel details including airline used:

____

____

Has patient been in physical contact with someone diagnosed with Ebola Disease?
Yes ________ No __________

Symptoms reported and date of appearance of symptoms:

____

____

____

Observed signs:

- ☐ Fever greater than 100.4 F (38C)
- ☐ Diarrhea
- ☐ Weakness
- ☐ Vomiting
- ☐ Bleeding
- ☐ Abdominal Tenderness

Assessment and Disposition ____

If patient suspected of having Ebola disease, obtain next of kin and household contact information on back of page.

CALL SACRAMENTO COUNTY PUBLIC HEALTH – (916) 875-5881

Suspect Ebola Patient Screening Tool for Sacramento County Response

Next of Kin Information

Name ____

Address ____

Phone ____

Relationship ____