County of Los Angeles Public Health

NIPAH VIRUS DISEASE CONTACT INVESTIGATION WORKSHEET FOR SYMPTOMATIC SUSPECT OR CONFIRMED CASE

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone), 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

Investigator Name: ______________________________ Investigator Phone: ________________ Date of Interview: ___________________

CASE INFORMATION

Case IRIS ID	Case Name (Last, First)	Case Date of Birth	Case Phone	Symptom Onset Date	Isolation Date	If Case Unavailable, Name of Person Interviewed.	Relationship to Case	Alternate Person's Phone

Instructions: After conducting the NiV Intake and Checklist interview, use this contact investigation form to elicit all contacts exposed to the suspect/confirmed Nipah Virus Disease (NiV) case after the symptom onset date. Record all information regarding exposed contacts on this form

Script: Now I'm going to ask you about any people you may have had direct or close contact (3 feet to 1 meter) after your symptoms began on [Insert Symptom o]. Please provide detailed information about each contact as much as possible. LAC DPH will need to reach out to these close contacts to notify them of their exposure so that they can self-monitor, quarantine and be informed of what they should do to keep themselves and their family safe. Your name will not be disclosed to the contact who we call. Will you be providing us with a list of recent contacts?

NiV Patient: ☐ Consented to Provide Contacts   Refused to Provide Contacts

POSSIBLE CONTACTS

Since your symptoms first began on ,		**Yes**	**No**	**Instructions**
HOUSEHOLD CONTACTS	Who have you been living with?	☐	☐	*[Record names and dates/Note on Pg.5]*
	Who else spent time at your home (eating meals, hanging out, sleeping over, used a share bathroom) but doesn't live with you?	☐	☐	*[Record names and dates/Note on Pg.5]*
	Who has slept in the same room with you?	☐	☐	*[Record names and dates/Note on Pg.5]*
	Who has taken care of you or cleaned up after you at home? (e.g.: laundry, washing utensils)	☐	☐	*[Record names and dates/Note on Pg.5]*
	Do you have a household member who is under your care? (e.g.: children, chronically ill family member)	☐	☐	*[Record names and dates/Note on Pg.5]*
	Do you have a pet that is under your care?	☐	☐	*[Record/Note on Pg.5]*
SEXUAL CONTACTS	Did you have any sexual contacts?	☐	☐	*[Record names and dates/Note on Pg.5]*
HEALTHCARE CONTACTS	Did you visit a health care facility (HCF)?	☐	☐	If Yes, Facility name ______________________ Address ______________________ Phone ____________ Dates visited ______________ Type of Facility: ☐ Hospital ☐ Clinic ☐ Urgent Care ☐ Other: ____________ Method of Visit: ☐ Private/Personal vehicle ☐ Ambulance ☐ Uber/Lyft/Ride Share ☐ Other: ______________ Who had direct physical contact with you*? *[Record names on Pg.5]* ***NEED TO CONDUCT A THOROUGH INVESTIGATION OF ALL HCW CONTACTS EXPOSED TO CASE – ASK FOR LOG OF ALL CONTACTS EXPOSED TO CASE AND LIST OF ALL PRE-HOSPITAL PERSONNEL (EMS, FIRE DEPARTMENT, LAW ENFORCEMENT).*
	Did you visit more than one HCF?	☐	☐	Please record the above information in Notes.

POSSIBLE CONTACTS (CONTINUED)				
Since your symptoms first began on [Insert symptom onse ,		**YES**	**NO**	**Instructions**
TRAVEL CONTACTS	Did you travel outside of LAC?	☐	☐	If Yes, Mode of travel: ☐ Plane ☐ Taxi ☐ Bus ☐ Cruise ☐ Uber/Lyft/Ride Share ☐ Other ________________________________ Bus line/train line/cruise flight number: ________________________ Where did your travel originate? _____________________________ What was your destination? ________________________________ Address of Hotel/Airbnb/House: _______________________________ Dates of travel: ____ Who traveled with you or had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
WORKPLACE CONTACTS	Employed?	☐	☐	If Yes, Business name ____ Address ____ Phone (____) ____________ Supervisor ____________________ Dates went to work: ____________________________________ Dates teleworked: ______________________________________ Who are the people that you had direct physical contact with or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
SCHOOL CONTACTS	Did you go to school?	☐	☐	If Yes, School name ____ Address ____ Phone (____) ____________ Principal/Administrator ____________________ Dates attended ____ Classes ____ Who are the people that you had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
SOCIAL EVENT CONTACTS	Did you attend any organized social event such as a party?	☐	☐	If Yes, Event name ____ Address ____ Host name ______________________ Phone (____) ____________ Dates of event ____ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*

CONFIDENTIAL – This material is subject to the Official Information Privilege Act

Case name (last, first) ____ IRIS ID# _______________

POSSIBLE CONTACTS (CONTINUED)				
Since your symptoms first began on ,		**YES**	**NO**	**Instructions**
BARS/CLUBS CONTACTS	Did you attend any bars or clubs?	☐	☐	If Yes, Bar/Club name ____ Address ____ Dates visited _____________________________________ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
FRIEND'S OR RELATIVE'S HOME	Did you go to friend's or relative's homes?	☐	☐	If Yes, Friend or relative name ____ Address ____ Dates visited _____________________________________ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
COMMUNITY CENTERS	Did you go to any community centers?	☐	☐	If Yes, Community center name _______________________________________ Address ____ Dates visited _____________________________________ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
RELIGIOUS SERVICE CONTACTS	Did you go to any religious services?	☐	☐	If Yes, Church/Temple/Mosque Name ___________________________________ Address ____ Dates visited ____ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
OTHER ACTIVITIES OR PLACES	Did you participate in any other activities or visit any other places (e.g.: gyms, group activities, concerts)?	☐	☐	If Yes, Place name ____ Address ____ Dates visited _____________________________________ Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
OTHER	Is there anyone else who may have had direct contact with your skin, blood and/or other body fluids (blood, , saliva, urine)?	☐	☐	Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
	Is there anyone else who may have touched any objects that may have been contaminated with your bodily fluids?	☐	☐	Who had direct physical contact with you or who shared a food dish, drinking cup, utensils, linens, or clothing with you? *[Record names on Pg.5]*
	Did you throw away any personal disposable items (e.g.: tissues, toothbrush, water bottle, diaper, sanitary pad, towels) that may have been contaminated with you bodily fluids?	☐	☐	Where are the disposed items currently:
MODE OF USUAL TRANSPORT	What is your usual mode of transport for your commute to work, school, and/or other errands?	☐	☐	☐ Personal Vehicle ☐ Bus ☐ Uber/Left/Rideshare ☐ Taxi ☐ Train ☐ Other:_____________ Provide the dates of when you used mass transits/ride share: _________________________ Provide details of the mass transits/ride share:

IF CASE DIED BEFORE NiV DIAGNOSIS, ASK THE FOLLOWING TO ALTERNATE CONTACT:				
FUNERAL/ BURIAL	Was there a viewing, a wake or a service for the case?	☐	☐	If Yes, Address of viewing, wake, or service. ______________ Funeral Home/Mortuary Name ______________ Address ______________ Phone ______________ Who had direct physical contact with the body? *[Record names on Pg.5]*

NOTES:

Instruction to Contacts

- It is very important for contact to self-monitor for symptomstwice a day and immediately report any symptoms to LAC DPH. LAC DPH physician will evaluate the individual and take appropriate actions.

LAC DPH Phone number: Business hours: 213-240-7941 Afterhours: 213-974-1234 (ask for physician on call)

- NiV Symptoms: Fever (≥ 100.4° F/38.0° C), Sore throat, Vomiting, Disorientation, Severe headache, Shortness of breath, Seizure, Mental confusion, Cough, Nausea, Drowsiness
- Inform contact that if any NiV symptoms develop, they should NOT go to healthcare provider, urgent care or hospital but instead call LAC DPH. If symptoms are life threating call 911.
- Inform contact that there are specialized hospitals that screen and treat for NiV, and prior approval for transportation to and treatment at these hospitals must be obtained from LAC DPH. Thus, it is important to notify LAC DPH if they feel unwell as early as possible.
- Inform contact that if they need medical attention, a special ambulance will be used to transport patient to hospital. Family members may not ride in the ambulance due to safety and infection control concerns.
- If contact is under 18 years old, inform the parents/guardian that they cannot ride with their child in the ambulance due to safety and infection control concerns. In addition, let the parents/guardian know that there may be some visitation restrictions per hospital policy.
- Inform contact that healthcare workers will be wearing PPE while they attend the individual. This may include gowns, hoods, masks, face shields and gloves.
- There may be a special visitor restrictions at the hospital, depending on hospital policy.
- Inform contact to refrain from posting anything related to their medical condition (i.e. symptoms) on social media. This may hinder or delay medical care and can compromise their health privacy.
- Inform contact that if they need medical attention at a specialized hospital, he/she should not to wear/bring expensive/valuable items (e.g. jewelry, electronics). These items may need to be decontaminated and could be either damaged or may not be returned for safety and contamination concerns.
- Inform contact to bring any medications or the list of the medications that he/she is taking when medical attention is needed at a specialized hospital.
- If not already obtained, LAC DPH will interview contact to obtain further information such as contacts who may have been exposed to the contact.
- Please create a go bag (items may not be returned to contact): Copy of photo ID card, List of emergency contacts, Work information, Medication list, Clothes
- If possible, create a plan of who can take care of the contact's family members and pet(s) and have a list of their contacts and caregiver contacts readily available.
- Inform contact that, if needed, DPH will coordinate decontamination of the residence.

Case name (last, first) ______________________________ IRIS ID# ____________

FORM B

CONTACT INFORMATION LIST

	FULL NAME	DOB	AGE	SEX	RELATIONSHIP TO CASE	DATE OF LAST CONTACT WITH CASE	TYPE OF CONTACT	EXPOSURE LOCATION (If HCF, provide facility name)	*RISK LEVEL	HEALTHCARE WORKER?	PHONE	RESIDENTIAL ADDRESS	CITY	ADDITIONAL NOTES
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Risk Classification: *Refer to the B-73 for NiV.*

Types of Contact:

- 1 = Had contact of percutaneous, mucous membrane or broken skin contact with blood or other body fluids (blood, saliva, urine) of the patient
- 2 = Had direct physical contact with the body of the patient (alive or dead).
- 3 = Touched or cleaned the personal belonging, bedding, linens, clothes, or dishes of the patient.
- 4 = Slept or ate in the same household as the patient.
- 5 = No physical contact but was within 3 feet or 1 meter with the patient.

Case name (last, first) ____________________ IRIS ID# ____________ **FORM B**

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	FULL NAME	DOB	AGE	SEX	RELATIONSHIP TO CASE	DATE OF LAST CONTACT WITH CASE	TYPE OF CONTACT	EXPOSURE LOCATION (If HCF, provide facility name)	*RISK LEVEL	HEALTHCARE WORKER?	PHONE	RESIDENTIAL ADDRESS	CITY	ADDITIONAL NOTES
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