BC Centre for Disease Control
An agency of the Provincial Health Services Authority

EBOLA VIRUS DISEASE WEEKLY CONTACT MONITORING FORM

Last Name:_____ First Name:_____ Date of Birth: _____ (yyyy/mm/dd)

Incubation period start (yyyy/mm/dd) _____ Incubation period end (yyyy/mm/dd) _____

Number of weeks since start of incubation period	**Follow-up Date**	**Temperature**	**Symptoms (check all that apply)**	**Onset** If yes, date reported symptom (yyyy/mm/dd)	**Comments/Action Items**	**Person completing assessment**
		Have you experienced a temperature of ≥38.0C ☐ Yes ☐ No ☐Unknown If yes, Exact temperature: Date:	☐ Fever ☐ Rash ☐ Headache ☐ Muscle pain ☐ Sore throat ☐ Haemorrhaging ☐ Conjunctivitis ☐ Chills ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Other, specify: _____ ☐ None		☐ Unable to contact Medications taken: Concern of non-compliance ☐ yes ☐ no Specify: ☐ referred to MHO and self-isolate due to symptoms ☐ specimen collected Notes:	

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