

**UN Medical Services Division**  
**Clinical Assessment Form for UN Personnel EXITING OUT FROM Ebola-Affected Countries**

(For details of current areas that have suspect / confirmed and their locations see <http://www.who.int/csr/don/archive/disease/ebola/en/>)

**This form is to be used by UN health care providers to assess the risk of a UN personnel being exposed to or infected with the Ebola virus disease.**

**For UN duty stations in EBOLA-AFFECTED COUNTRIES:**

- All UN personnel exiting and planning to travel from Ebola-affected countries to NON-Ebola-affected-countries, should have this form completed by their UN medical officer BEFORE they exit the Ebola-affected country.
- A copy of the completed form should be e-mailed to the Medical Officer at the UN personnel's final travel destination.

**For all UN duty stations:**

- UN medical staff may use this form to assess the Ebola risk of any UN personnel returning to their duty station after travel to an Ebola-affected country.
- All individuals who are planning to travel to an Ebola-affected country should be provided a copy of this form, and advised to have them completed before they exit and leave the Ebola-affected country.

**PLEASE NOTE THAT PPE MUST BE USED AT ALL TIMES WHEN INTERACTING WITH INDIVIDUALS WHO ARE UNWELL. ALL INDIVIDUALS WHO ARE UNWELL AND HAVE BEEN IN CONTACT WITH A SUSPECTED OR KNOWN CASE NEED TO IMMEDIATELY BE PLACED IN ISOLATION<sup>1</sup>.**

Date and Time of this Assessment (dd/mm/yy): \_\_\_\_\_ Duty station: \_\_\_\_\_

**A) UN STAFF/PERSONNEL DETAILS**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Index No: \_\_\_\_\_ DOB (dd/mm/yy): \_\_\_\_\_  
Sex: M/F Current Duty Station: \_\_\_\_\_ Organization/Office: \_\_\_\_\_ Title: \_\_\_\_\_  
Email: \_\_\_\_\_ Tel No: \_\_\_\_\_  
Emergency Contact -- Name: \_\_\_\_\_ Tel No: \_\_\_\_\_ Email: \_\_\_\_\_

**B) TRAVEL HISTORY**

In the last 3 weeks, has the individual travelled to a specific locality / area that currently has suspect/confirmed Ebola cases?  
 Yes  No  Unknown If yes or unknown, please specify which Country/City/Region/Town: \_\_\_\_\_

**C) CURRENT HEALTH STATUS**

Please check off whichever applies:  The individual is currently well, and has no signs or symptoms.  
 The individual is currently unwell, and has signs/symptoms.

**D) SIGNS & SYMPTOMS (TO BE COMPLETED IF INDIVIDUAL IS UNWELL)**

Date of onset of first symptoms (dd/mm/yy): \_\_\_\_\_ Was onset of symptoms sudden or gradual?  Sudden onset  Gradual onset

Please indicate if the patient has the following signs and/or symptoms:

<b>Fever &gt;38C</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Diarrhoea</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>History of fever</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Restroternal pain</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Fever &gt;38 persisting 72 hours after use of antimalarials or antimicrobials</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Haematemesis</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Headache</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Malaena</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Rash</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Bleeding</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Myalgia</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Bruising</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Cough</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>BP systolic &lt;99 mmHg</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Pharyngitis</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Resp rate &gt;20/min</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Vomiting</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Pulse &gt;90 bpm</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
				<b>Other</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

If other symptoms, please specify: \_\_\_\_\_

<sup>1</sup> Please refer to WHO's " *Interim Infection prevention and control guidance for care of patients with Suspected or Confirmed Filovirus Haemorrhagic fever in health-care settings, with focus on Ebola* " (August 2014), available at [http://www.who.int/csr/bioriskreduction/filovirus\\_infection\\_control/en/](http://www.who.int/csr/bioriskreduction/filovirus_infection_control/en/)

**E) ASSESSMENT OF EPIDEMIOLOGICAL RISK FACTORS**

The following table lists some potential epidemiological risk factors that might expose an individual to the Ebola virus. Did the individual encounter any of the following? (Please check off the boxes that apply):

	Yes	No	Unknown
<i>In the past 21 days, came into contact with body fluids of a live or dead individual known or strongly suspected to have Ebola virus disease either <u>directly</u>, e.g. handled blood, urine, or <u>indirectly</u>, e.g. soiled clothes or bedding?</i>			
<i>In the past 21 days, have had close contact with a live or dead individual known or strongly suspected to have Ebola virus disease?</i>			
<i>In the past 21 days, been involved in the funeral preparations of an individual known or strongly suspected to have Ebola virus disease?</i>			
<i>In the past 3 months, have had sex with an individual known or strongly suspected to have Ebola virus disease?</i>			
<i>In the past 21 days, have handled clinical/laboratory specimens (blood, urine, faeces, tissues, laboratory cultures) from a live or dead individual or animal known or strongly suspected to have Ebola virus disease?</i>			
<i>In the past 21 days, came into contact with the body fluids of, or had direct contact with, a live or dead individual or animal, known or strongly suspected to have Ebola virus disease (e.g. routine patient care, transport of patient, resuscitation, autopsy)?</i>			
<i>In the past 21 days, received any intra-muscular or intra-venous injections in an Ebola outbreak area?</i>			
<i>In the past 21 days, handled or butchered dead primates or been involved in drying, smoking their meat or consuming their meat in an Ebola virus disease outbreak area?</i>			
<i>In the past 21 days, visited any health care facility/ies in the Ebola-affected country?</i>			
<i>In the past 21 days, visited or had casual contact with an Ebola patient? [Casual contact is defined as being within 3 feet of patient, or having brief direct contact (eg shaking hands) without wearing recommended PPE.]</i>			
<i>Does the individual have family or household members in this country who are suspect/confirmed Ebola cases?</i>			

**F) FINAL ASSESSMENT ON RISK**

After interview/exam of the UN staff or personnel, my medical assessment is as follows:

<b>RISK CATEGORY</b>	<b>CRITERIA</b>
<input type="checkbox"/> <b>Suspected Case</b>	Individual has a sudden onset of high fever or any other signs and symptoms + has at least one epidemiological risk factor (Section E); OR Individual has a sudden onset of high fever and at least three other signs and symptoms
<input type="checkbox"/> <b>High/Moderate Risk</b>	Individual is ill, with at least <b>ONE</b> sign and symptom but declares they have <b>NO</b> epidemiological risk factors (Section E).
<input type="checkbox"/> <b>Suspected Contact</b>	Individual has <b>NO</b> signs / symptoms, but has at least <b>ONE</b> epidemiological risk factor (Section E).
<input type="checkbox"/> <b>Low Risk</b>	Individual is well with NO signs/symptoms and declares they have <b>NO</b> epidemiological risk factors (Section E).

If individual is determined as a “Suspected Case”, “High/Moderate Risk” or “Suspected Contact”, please discuss the individual’s travel plans and movement with local Outbreak Management team/local health authorities. Please ensure that the individual complies with all public health directives from the Host country and WHO.

*I certify that this clinical assessment has been completed and appropriate follow up actions taken for this individual. Please Check here.*

SIGNATURE OF HEALTH CARE PROVIDER: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_ Duty Station: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Tel: \_\_\_\_\_ Email: \_\_\_\_\_