Tool for Surveillance Among Facilities Housing Hurricane Katrina Evacuees

SUBMIT THIS FORM DAILY TO STATE OR LOCAL HEALTH AUTHORITIES by email or fax.

Please call your state or local health authorities if unable to fax or email, or to report unusual disease occurrences.

Facility name: _____ Phone:_____-_____-_____ Fax:_____-_____-_____

Email:_____ Reported by: _____

CURRENT FACILITY CENSUS: TOTAL: _____ AGE: ≤2 y _____ >65 y: _____

RACE: White _____ Black: _____ Am Ind: _____ Asian: ____ Other: _____ HISPANIC ETHNICITY: _____

24 hr reporting period: Date: ___ /___/____ Time _____am pm (circle one) **TO** ___/ ___/____ Time_____am pm

INSTRUCTIONS: You may count a person more than once BUT be as specific as possible. ***For example, if you suspect measles, classify as such, otherwise classify as rash illness; OR if person has more than one GI symptom, select the most severe.***

Syndrome Category	# patients with condition
Epidemic Disease Potential	
Fever >100.4° F (38° C) ALONE without localizing signs/ symptoms.	___ ___ ___
Gastrointestinal Illness	___ ___ ___
Watery Diarrhea (3 or more watery bowel movements per day) AND vomiting	___ ___ ___
Watery Diarrhea with NO vomiting	___ ___ ___
Bloody Diarrhea, +/- vomiting	___ ___ ___
Respiratory illness	___ ___ ___
Upper respiratory or influenza-like illness (fever + either cough or sore throat)	___ ___ ___
Tuberculosis, suspected (cough ≥3 weeks, fever/chills, night sweats, recent weight loss)	___ ___ ___
Pertussis, suspected (whooping cough; chronic cough ≥ 2 weeks)	___ ___ ___
Lower respiratory tract illness (pneumonia; bronchiolitis/wheezing)	___ ___ ___
Viral hepatitis, suspected (jaundice, +/- fever)	___ ___ ___
Neurologic illness	___ ___ ___
Meningitis/encephalitis, suspected (fever, stiff neck, headache, mental status change)	___ ___ ___
Wound infections	___ ___ ___
Conjunctivitis (red eyes, ocular discharge)	___ ___ ___
Rash Illness	___ ___ ___
Suspect chickenpox (vesicular rash)	___ ___ ___
Suspect measles/rubella (maculopapular rash)	___ ___ ___
Scabies	___ ___ ___
Lice	___ ___ ___
Other Illness (*please specify*): _____	___ ___ ___
Mental Health / Psychological Problems	
Mental Health	___ ___ ___
Anxiety / Depression / Insomnia	___ ___ ___
Substance abuse / withdrawal	___ ___ ___
Disorientation / Confusion	___ ___ ___
Acute psychosis / Suicidal or Homicidal	___ ___ ___
Violent behavior	___ ___ ___
Injury / Chronic Disease / Other	
Injury	___ ___ ___
Self-inflicted injury – Intentional (violence)	___ ___ ___
Assault-related injury – Intentional (violence)	___ ___ ___
Unintentional injury (accidents)	___ ___ ___
Heat related injury (not dehydration)	___ ___ ___
Diabetes Mellitus	___ ___ ___
Asthma / COPD	___ ___ ___
High Blood Pressure and other Cardiovascular Diseases	___ ___ ___
Dehydration	___ ___ ___

Are you concerned about a possible outbreak? (*Please describe*): _____

Total number of patients treated in past 24 hour period: _____ Total number of deaths during past 24 hours: _____

Do you need assistance with, or additional resources for any of the following:

	Yes	No		Yes	No
Physician staffing	□	□	Nursing staffing	□	□
Pharmacist staffing	□	□	Mental Health staffing	□	□
Sanitation/Environmental health	□	□	Medications/Drugs/Pharmacy supply	□	□