Sultanate of Oman Ministry of Health

# EVD Contacts Follow-up Form

**Patient's Name:** ________________________ **Governorate** ____________ **Institution**________________

**Contacts Category: Community** ☐ **Health care** ☐ **Port-of-Entry** ☐

MH/EVD/Co/F2/Ver.1.0/Aug 2014

| # | Name | Age | Sex | Date of last exposure | Days of Follow up | | | | | | | | | | | | | | | | | | | | |
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**Note:** 1. Record twice daily **"Y"** if the contact has developed **fever** OR **other symptoms consistent with EVD*** and record **"N"** if the patient has **NOT** developed any symptoms

2. Complete the case investigation form and refer to the hospital and follow the **'Case Investigation and Reporting Algorithm'**

***Other symptoms of EVD: Headache, muscle pain, vomiting, diarrhea, abdominal pain and bleeding inside or outside the body**