Policy Statement

This policy serves as a guide for the prevention and control of transmission of Ebola Virus Disease (EVD) at the Philippine Heart Center.

Case Definition

A. Person Under Investigation (PUI)

Any person arriving in the Philippines with history of travel within the past 21 days or residence in EVD outbreak affected countries including Guinea, Liberia, Sierra Leone, and Nigeria or contact/s with confirmed cases.

B. Suspect Case:

A Person Under Investigation who develops signs and symptoms during the 21-day quarantine period or any person with acute onset of fever with at least any three of the following:

- Headache
- Vomiting
- Anorexia / loss of appetite
- Diarrhea
- Lethargy/Drowsiness
- Stomach/Abdominal pain
- Aching muscles or joints
- Sore Throat /Difficulty swallowing
- Breathing difficulties
- Bleeding from any site

AND
With epidemiologic risk factors within the past 21 days before the onset of symptoms, such as contact with blood or other body fluids or human remains of a patient known to have or suspected to have EVD; residence in – or travel to-an area where EVD transmission is active; or direct handling of bats, rodents, or primates from disease-endemic areas.

C. Probable Case

Any suspected case evaluated by a clinician/epidemiologist having an epidemiological link with confirmed case (where it has been possible to collect specimens for laboratory confirmation.

OR

Any deceased suspected case (where it has not been possible to collect specimens for laboratory confirmation) having an epidemiological link with a confirmed case.

D. Laboratory Confirmed Case

Any suspect or probable cases with a positive laboratory result. Laboratory confirmed cases must test positive for the virus antigen, either by detection of virus RNA by reverse transcriptase-polymerase chain reaction (RT-PCR), or by detection of IgM by Enzyme-Linked Immunosorbent Assay (ELISA) or IgM antibodies directed against Ebola.

E. Discarded Case

Any suspected or probable case with a negative laboratory result. “Discarded Case” showed no specific antibodies, RNA or specific detectable antigens.
Key Messages

*All suspected, probable and/or confirmed Ebola cases shall be transferred to DOH Referral Hospitals (Research Institute for Tropical Medicine (RITM), San Lazaro Hospital and Lung Center of the Philippines).

*While awaiting transport, isolate suspected/probable and/or confirmed Ebola cases in single isolation rooms or cohort them in specific areas while keeping suspected/probable and confirmed cases separate.

*Ensure restricted access to these areas.

*Exclusively assign clinical and non clinical personnel to Ebola patient care areas.

*Ensure that all personnel entering the patient isolation rooms/areas rigorously use personal protective equipment (PPE) and perform hand hygiene as indicated.

*PPE should include: gloves, impervious gown, boots/closed shoes with overshoes, N95 mask and full eye protection either as goggles or full face shield.

*Ensure use of dedicated equipment.

*Ensure safety of injections and phlebotomy procedures and management of sharps.

*Ensure regular and rigorous environmental cleaning, decontamination of surfaces and equipment, and management of soiled linen and of waste as indicated.

*Ensure safe processing of laboratory samples from suspected or confirmed patients with EVD.

*Ensure that the Infection Prevention and Control measures indicated are followed while handling dead bodies or human remains of suspected or confirmed patients with EVD for post mortem examination and burial preparation. (see page 12)

*Promptly evaluate, care for, and if necessary, isolate healthcare workers or any person exposed to blood or body fluids from suspected or confirmed patients with EVD.
1. GENERAL PATIENT CARE

Standard, contact and droplet precautions are recommended for management of hospitalized patients with known or suspected Ebola Virus Disease (EVD).

- Standard precaution shall be applied when providing care to ALL patients regardless of their condition at the time of consult because the initial manifestations of EVD may be non-specific.
- Hand hygiene is the most important measure.
- Gloves shall be worn for any contact with blood or body fluid.
- N95 mask and goggles or face shield shall be used if there is any potential for splashes of blood or body fluids and during cleaning of contaminated surfaces.

2. DIRECT PATIENT CARE

SCREENING AND TRIAGE

Infection control precautions begins at screening and triage (Annex A) for any patient with compatible symptoms and a history of travel to an area of EVD transmission. Assessment and interviews shall be performed at the Triage Tent. A distance of more than one meter shall be maintained between interviewer and interviewee.

PATIENT PLACEMENT

- All suspected, probable and/or confirmed EVD cases shall be placed at the ER Isolation Room located in front of the hospital entrance while awaiting transport to DOH referral hospital.
- If single isolation rooms are unavailable, cohort patients in specific confined areas keeping suspected, probable and confirmed cases separate.
- The isolation room shall have an adjoining dedicated bathroom, sink with running water, soap and single use towels, alcohol-based hand rub dispensers, stocks of personal protective equipment (PPE), stocks of medicines, good ventilation, screened windows, doors closed and restricted access.
- At least 1 meter (3 feet) distance between patient bed is preferred.
STAFF ALLOCATION

• A log of all persons entering the patient's isolation area shall be maintained.
• All clinical and non-clinical personnel assigned exclusively to EVD patient care areas shall not move freely between other clinical areas during the outbreak.
• Restrict all non-essential staff from EVD patient care areas.

VISITORS

• NO visitors policy will be implemented.
  • Exceptions may be considered on a case to case basis for those who are essential for the patient's well being and care such as a child's parent. In this case, the following measures shall be observed:
    • Screening for EVD (e.g. fever and other symptoms) before entering or upon arrival to the hospital
    • Evaluating risk to the health of the visitor and ability to comply with precautions
    • Providing instruction, before entry into the patient care area on hand hygiene, limiting surfaces touched, and use of PPE
  • Do not allow other visitors to enter the isolation rooms/areas other than those allowed as described above and ensure that any visitor or Healthcare providers (HCP) wishing to observe the patient do so from an adequate distance (approximately 15m or 50 feet).

HAND HYGIENE

Healthcare providers shall perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Ensure that hand hygiene is properly performed as indicated. (see Policy on Hand Hygiene)
PERSONAL PROTECTIVE EQUIPMENT (PPE) AND OTHER PRECAUTIONS

The different circumstances of facilities in areas of EVD transmission has resulted in the use of near total body covering by HCPs while caring for EVD patients. These include dirt floors, make shift tents, multiple patients in one area some of whom may be quite ill, high patient to HCP ratios, no or limited electricity and running water, high ambient temperatures, extensive environmental contamination with infected body fluids and limited resources for environmental decontamination. Even in such difficult settings control of EVD transmission in outbreaks has been achieved with contact and droplet isolation and guidance developed that is quite instructive. The evidence base for CDC infection control recommendations from experience gained during Ebola outbreaks show that even in households of EVD patients where secondary cases occurred, blood exposure, not shared airspace, was the risk factor for transmission. The categorical use of PPE or engineering controls beyond contact and droplet for every suspected EVD patient is not supported at this time.

- Risk Assessment is important in guiding the HCP on which PPE to use.
- Recommended PPE shall be worn by HCP upon entry into patient rooms or care areas.
  - Upon exit from the patient room or care area, PPE shall be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials, and properly discarded.
  - Instructions of donning and doffing are posted in the ante room.
  - Hand hygiene shall be performed immediately after removal of PPE.
- Key components of PPE include fluid resistant or impermeable gowns, fluid – resistant face mask to cover nose and mouth, full eye protection either as goggles or full face shield, and gloves.
- Head covering, impermeable leg covering and shoe covering would be used in clinical circumstances, in which there are, or are likely to be, uncontrolled splashes and/or environmental contamination with biological fluids (blood, diarrheal stool, urine, and vomitus).
- Appropriate training in and monitoring of safe removal of PPE is critical to minimize exposures of healthcare personnel.
- Ensure that all HCWs (including aides and cleaners) wear PPE properly as appropriate according to the expected level of risk before entering the isolation rooms/areas and having contacts with the patients and/or environment.
- Ensure that all visitors use PPE as indicated below and are provided with related instructions prior to entry into the isolation room/area.
- Personal clothing shall not be worn for working in the patient areas. Scrub or medical suits shall be worn.
AEROSAL GENERATING PROCEDURES (AGP)

- Procedures or circumstances in which aerosols may be generated (bronchoscopy, sputum induction, intubation and extubation, and open suctioning of airways) shall include additional environmental and PPE measures for airborne precautions such as negative pressure room and N-95 or greater filtering respirator.
- Limit the number of HCP present during the procedure to only those essential for patient-care and support.
- Conduct the procedures in a private room and ideally in an Airborne Infection Isolation Room when feasible. Room doors shall be kept closed during the procedure except when entering or leaving the room, and entry and exit shall be minimized during and shortly after the procedure.
- HCP shall wear gloves, an impermeable gown, disposable shoe covers, and either a face shield that fully covers the front and sides of the face or goggles, and a fit-tested N95 respirator or higher.
- Visitors shall not be present during AGP.
- Conduct environmental surface cleaning following procedures.

INJECTION SAFETY AND MANAGEMENT OF SHARPS

- Any injection equipment or parenteral medication container that enters the patient treatment area shall be dedicated to that patient and disposed of at the point of use.
- Limit the use of needles and other sharp objects as much as possible.
- Limit the use of phlebotomy and laboratory testing to the minimum necessary for essential diagnostic evaluation and patient care.
- If the use of sharp objects cannot be avoided, ensure the following precautions are observed:
  - Never replace the cap on a used needle.
  - Never direct the point of a used needle towards any part of the body.
  - Do not remove used needles from disposable syringes by hand, and do not bend, break or otherwise manipulate used needles by hand.
  - Dispose of syringes, needles, scalpel blades and other sharp objects in appropriate puncture-resistant containers.
• Ensure that puncture-resistant containers for sharps objects are placed as close as possible to the immediate area where the objects are being used ('point of use') to limit the distance between use and disposal, and ensure the containers remain upright at all times. If the sharps container is far, never carry sharps in your hand but place them all in a kidney dish or similar to carry to the sharps container.
• Ensure that the puncture-resistant containers are securely sealed with a lid and replaced when ¾ full.
• Ensure the containers are placed in an area that is not easily accessible by visitors, particularly children (e.g. containers shall not be placed on floors or on the lower shelves of trolleys in areas where children might gain access).

3. ENVIRONMENTAL CLEANING AND MANAGEMENT OF LINEN

PPE

• Wear heavy duty/rubber gloves, impermeable gown and closed shoes (e.g. boots) when cleaning the environment and handling infectious waste including linen. In addition, wear facial protection (mask and goggle or face shield) and overshoes if boots are unavailable, when undertaking activities with increased risk of splashes or in which contact with blood and body fluids is anticipated (e.g., washing linen, cleaning surfaces heavily soiled with vomit or blood or cleaning areas closer than 1 meter / 3 feet from a patient with symptoms like diarrhea, bleeding or vomiting, etc.).
CLEANING PROCESS

- Environmental surfaces or objects contaminated with blood, other body fluids, secretions or excretions shall be cleaned and disinfected as soon as possible.
- Use a disinfectant with a label claim for a non-enveloped virus (e.g. norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces in rooms of patients with suspected or confirmed Ebola virus infection.
  - Enveloped viruses such as Ebola are susceptible to a broad range of hospital disinfectants used to disinfect hard, non-porous surfaces.
  - In contrast, non-enveloped viruses are more resistant to disinfectants.
  - EPA-registered hospital disinfectants with label claims against non-enveloped viruses are broadly antiviral and capable of inactivating both enveloped and non-enveloped viruses.
- Application of disinfectants shall be preceded by cleaning to prevent inactivation of disinfectants by organic matter.
- Clean floors and horizontal work surfaces at least once a day with clean water and detergent. Cleaning with a moistened cloth helps to avoid contaminating the air and other surfaces with airborne particles. Allow surfaces to dry naturally before using them again.
- Dry sweeping with a broom shall never be done. Rags holding dust shall not be shaken out and surfaces shall not be cleaned with dry rags.
- Cleaning shall always be carried out from 'clean' areas to 'dirty' areas, to avoid cross contamination.
- Do not spray (i.e. fog) occupied or unoccupied clinical areas with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

MANAGEMENT OF LINEN

- Linen used shall be transported directly to the laundry area. This has to be laundered promptly with water and detergent.
  - Soiled linen shall be placed in clearly-labelled, leak-proof yellow bags (may do double bagging) or buckets at the site of use and the container surfaces shall be disinfected before removal from the isolation room/area.
• If the linen is transported out of the patient room/area for this procedure, it shall be put in a separate container – it shall never be carried against the body.
• Washing contaminated linen by hand shall be discouraged.
• For low temperature laundering, wash linen with detergent and water, rinse and then soak in 0.05% chlorine for approximately 30 mins. Linen shall then be dried according to routine standards and procedures.
• If safe cleaning and disinfection of heavily soiled linen is not possible or reliable, it may be prudent to burn the linen to avoid any unnecessary risks to individuals handling these items.

4. WASTE MANAGEMENT

PPE

• Wear heavy duty/rubber gloves, impermeable gown, closed shoes (e.g. boots) and facial protection (mask and goggles or face shield), when handling infectious waste (e.g. solid waste or any secretion or excretion with visible blood even if it originated from a normally sterile body cavity).
  • Goggles provide greater protection than visors from splashes that may come from below when pouring liquid waste from a bucket. Avoid splashing when disposing of liquid infectious waste.

WASTE MANAGEMENT PROCEDURES

• Waste shall be segregated at point of generation to enable appropriate and safe handling.
• Sharp objects (e.g. needles, syringes, glass article) and tubing that has been in contact with blood or body fluids shall be placed inside puncture resistant waste containers. These shall be located as close as practical to the patient care area where the items are used, similarly in laboratories.
• Collect all solid, non-sharp, infectious waste using leak-proof waste bags and covered bins. Bins shall never be carried against the body (e.g. on the shoulder).
• The area designated for the disposal of waste shall have controlled access to prevent entry by animals, untrained personnel or children.
• Waste, such as feces, urine and vomit, and liquid waste from washing, can be disposed of in the sanitary sewer. No further treatment is necessary.
5. NON – PATIENT CARE ACTIVITIES

A. DIAGNOSTIC LABORATORY ACTIVITIES

• All suspect or probable cases warrant collection of appropriate specimens by trained, skilled health provider for immediate laboratory testing using standard infection control precautions.

• Any person collecting and testing specimens from a patient with a case of suspected Ebola virus disease shall wear gloves, water resistant gowns, full face shield or goggles, and N95 masks to cover all of nose and mouth. As an added precaution, use a certified class II Biosafety cabinet with PPE may be required in certain situations to protect skin and mucous membranes.

• The following are the specimens to be collected for suspected cases of EBOLA virus disease.
  a. 2 ml of each of whole blood (using a violet top tube) and
  b. 2 ml serum (yellow top tube with separator)

• All laboratory sample processing must take place under a safety cabinet or at least a fume cabinet with exhaust ventilation.

• Specimen should be transported using a cold chain, maintaining temperature between 5-8 degrees Centigrade.

• Do not carry out any procedure on the open bench.

• Activities such as micro-pipetting and centrifugation can mechanically generate fine aerosols that might pose a risk of transmission of infection through inhalation as well as the risk of direct exposure.
  • Laboratory personnel handling potential EVD clinical specimens shall wear closed shoes with overshoes or boots, gloves, a disposable, impermeable gown, eye protection or face shields, and particulate respirators (N95), or powered air purifying respirators when aliquotting, performing centrifugation or undertaking any other procedure that may generate aerosols.

• Do not hang up the apron or gown for reuse. Discard immediately.

• Perform hand hygiene immediately after the removal of PPE used during specimen handling and after any contact with potentially contaminated surfaces even when PPE is worn.

• Place specimens in clearly labeled, non-glass, leak proof containers and deliver directly to designated specimen handling areas.

• Disinfect all external surfaces of specimen containers thoroughly prior to transport.
B. MOVEMENT AND BURIAL REMAINS

- The infection prevention and control staff shall be consulted for any decision making on movement and burial of human remains.
- The handling of human remains shall be kept to a minimum. The following recommendations shall be adhered to in principle, but may need some adaptation to take account of cultural and religious concerns:
  - Wear PPE (impermeable gown, mask, eye protection, double gloves and cap) and closed shoes or boots to handle the dead body of a suspected or confirmed case of EVD. Plug the natural orifices.
  - Place the body in a double bag, wipe over the surface of each body bag with a suitable disinfectant (e.g., 0.5% chlorine solution) and seal and label with the indication of highly-infectious material.
  - Immediately move the body to the mortuary.
- PPE shall be put on at the site of collection of human remains, worn during the process of collection and placement in body bags, and shall be removed immediately after. Hand Hygiene shall be performed immediately following the removal of PPE.
- Remains shall not be sprayed, washed or embalmed. Any practice of washing the remains in preparation of “clean burials” shall be discouraged.
- Only trained personnel shall remain during the outbreaks.
- PPE is not required for individuals driving a vehicle to collect human remains, provided that drivers or companions will not be handling a dead body of a suspected or confirmed case of EVD.
- After wrapping in sealed, leak-proof material, remains should be placed inside a coffin if possible, and buried promptly within 12 hrs.

C. POST-MORTEM EXAMINATIONS

- Due to the absence of adequate facilities, post mortem examination shall not be conducted on remains of suspected, probable or diagnosed to have EVD.

INFECTION PREVENTION AND CONTROL

POLICY MANUAL

EBOLA VIRUS DISEASE

Reviewed by INFECTION PREVENTION AND CONTROL TEAM

Approved by MANUEL T. CHUA CHIACO, M.D.
D. MONITORING AND MANAGEMENT OF POTENTIALLY EXPOSED PERSONNEL

- Persons with percutaneous or mucocutaneous exposures to blood, body fluids, secretions, or excretions from a patient with suspected EVD shall:
  - Stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (e.g. conjunctiva) shall be irrigated with copious amounts of water or eyewash solution.

- Immediately contact direct supervisor and Infection Control Committee (ICC) for assessment and access to post exposure management services for all appropriate pathogens (e.g. HIV, Hep C, etc.). This is a time sensitive task and shall be performed as soon as the HCP leaves the patient care unit.

- HCP who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an unprotected exposure (i.e. not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with EVD shall:
  - Not report to work or should immediately stop working
  - Notify their supervisor/ InfectionControl Office
  - Seek prompt medical evaluation and testing
  - Comply with work exclusion until they are deemed no longer infectious to others

- For asymptomatic HCP who had an unprotected exposure to a patient with EVD shall:
  - Receive medical evaluation and follow up care including fever monitoring twice daily for 21 days after the last known exposure
  - May continue to work while receiving twice daily fever checks

- Immediate consultation with an expert in infectious diseases is recommended for any exposed person who develops fever within 21 days of exposure.

- Contact tracing and follow up of family, friends, co-workers and other patients, who may have been exposed to EVD through close contact with infected HCP is essential.
REFERENCES:

1. WHO: Interim Infection Prevention and Control Guidance for Care of Patients with Suspected or Confirmed Filovirus Haemorrhagic Fever in Healthcare Settings, with Focus on Ebola; September 2014


ANNEX A

GUIDELINES FOR THE EVALUATION / MANAGEMENT OF SUSPECTED / DIAGNOSED WITH EBOLA VIRUS DISEASE (EVD)

1. The Philippine Heart Center shall have postings on EBOLA Alert in all entrances of the institution.

2. The guards manning the entrances shall ask all persons entering the Philippine Heart Center, for consultation, treatment and other concerns, if they have the symptoms and other related criteria for Ebola virus disease.

   2.1 If with symptoms and other related criteria for EVD, patient and/or significant others shall be directed by the guard to the Triage Tent located at the parking area near the Emergency Room in front of the hospital entrance and Figaro.

   2.2 If without the symptoms and other related criteria for EVD, they shall proceed to wherever they need to be.

3. The triage tent shall be manned by a staff nurse 24 hours a day.

4. The triage tent nurse shall use mask (N95) and gloves when interviewing a PUI, suspected or probable case and a distance of more than one meter shall be maintained between interviewer and interviewee.

5. The assigned doctor in the triage tent shall assess a patient under investigation, suspected case or probable case using the proper PPEs (face shield/goggles, N95 mask, gloves, impermeable gown, cap/head covering, boots/ disposable shoe cover/overshoes).

6. All Philippine Heart Center staff manning the triage tent (triage nurses, doctors, and other healthcare workers, including the janitorial service personnel) shall wear the appropriate personal protective equipment (PPEs) and practice standard precautions at all times.

7. The triage tent nurse shall document if patient has history of travel to and/or contact with people who traveled to identified cities/countries where there is an outbreak of EVD by accomplishing the Triage Screening Form for EVD. (Annex 1)
8. Likewise, the triage tent nurse shall document if patient had contact with a diagnosed case of EVD and manifests fever and other symptoms such as headache, vomiting, anorexia / loss of appetite, bloody diarrhea, lethargy, hiccups, stomach pain, aching muscles or joints, difficulty swallowing, breathing difficulties, bleeding from gums and bleeding into skin (purpura), eyes and urine.

9. If the patient has a history of travel and/or contact but does not manifest fever and the other symptoms of EVD, he shall then be managed clinically as indicated and quarantined by the Bureau of Quarantine (BOQ). Likewise, RITM and DOH shall be informed.

9.1 If the patient manifests the above mentioned symptoms of EVD while on quarantine (within 21 days), BOQ shall inform RITM and DOH.

9.2 If the patient does not manifests the above mentioned symptoms of EVD, this will be considered as non-EVD case and thus, discontinue quarantine.

10. If the patient has history of travel and/or contact and manifests the above mentioned signs and symptoms, he is then classified as a suspected case of EVD and shall be placed at the ER's isolation room, while awaiting transfer to a DOH referral hospitals (Research Institute for Tropical Medicine, San Lazaro Hospital and Lung Center of the Philippines).

11. All suspected case of EVD shall be transferred to a DOH referral hospital, thru ambulance, accompanied by the Triage Tent Nurse using the proper PPEs.

12. The triage doctor shall refer to the Infectious Disease Consultant for further instructions/recommendations and carry out all orders given.

13. The triage tent nurse shall inform the Hospital Infection Control Officer (HICO) and Infection Control Nurse (ICN) of the suspected case.

14. The HICO/ICN shall check the data acquired by the Triage Doctor and Triage Tent Nurse and if proper PPEs are worn.

15. The HICO/ICN shall report all PUI and EVD cases (suspect or probable) to the DOH's National Epidemiology Center as soon as possible or within 24 hours, using a properly filled out case notification forms (Annex 2).

16. The reporting entity (Epidemiology Surveillance Unit, hospitals/health facilities or responsible person/s) shall ensure proper and complete notification while observing privacy and confidentiality on all Information gathered for this purpose.
17. The charge nurse / designated ER nurse shall report to the HEMB the number of cases (PUI, suspected, probable, confirmed) seen at the Philippine Heart Center, including contact references as per DOH protocol.
FLOWCHART FOR EVALUATION / MANAGEMENT OF PATIENTS FROM EBOLA AFFECTED COUNTRIES

PATIENTS UNDER INVESTIGATION
Patient with history of travel and/or with contact with persons who traveled to Ebola affected countries (Guinea, Liberia, Sierra Leone & Nigeria)
OR
Contact of confirmed case

Fever + 3 of the following symptoms:
- Headache
- Loss of appetite
- Diarrhea
- Abdominal pain
- Vomiting
- Muscle pain
- Sore throat
- Drowsiness
- Bleeding from any site

YES

EVD SUSPECT / PROBABLE CASE*
- Inform NEC or RESU
- Transfer to DOH Referral Hospitals
- Supportive management

NO

Quarantine for 21 days
c/o Bureau of Quarantine
Inform Bureau of Quarantine, RITM and DOH

Develops symptoms within 21 days

YES

EVD SUSPECT / PROBABLE CASE*
Advise to call DOH hotline

NO

NON-EBOLA CASE
Discontinue quarantine
# ANNEX 1:

**TRIAGE SCREENING FORM (Adapted from RITM)**

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<td>Sex: ______________</td>
<td>Occupation: _____________________________________</td>
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<td>Home Phone Number:_______________________</td>
<td>Mobile Phone Number:______________________</td>
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**EPIDEMIOLOGICAL CRITERIA:**

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<tr>
<td><strong>Did you travel to any of these places in West Africa: Guinea, Liberia, Sierra Leone or Nigeria in the past 21 days?</strong></td>
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<tr>
<td><strong>In the past 21 days, have you ever cared for, lived with or had direct contact with the bodily fluids such as blood, saliva, sweat of a suspect/probable/confirmed patient with Ebola viral disease (EVD)?</strong></td>
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<td><strong>In the past 21 days, did you have close contact with a live or dead individual strongly suspected to have EVD?</strong></td>
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<td><strong>In the past 21 days, did you handle clinical or laboratory specimens (blood, urine, feces, tissues, laboratory cultures) from a live or dead individual or animal known or strongly suspected to have RVD?</strong></td>
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<td><strong>In the past 21 days, did you receive any intramuscular or intravenous injection in an Ebola outbreak area?</strong></td>
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<td><strong>In the past 21 days, did you handle or butcher dead primates; or was involved in drying, smoking consuming their meat in an EVD outbreak area?</strong></td>
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**CLINICAL AREA**

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<tr>
<td><strong>Did you have fever (≥ 38 °C) in the past 21 days?</strong></td>
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<td><strong>Did you have any of the following symptoms within THE PAST 21 DAYS?</strong></td>
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<tr>
<td>Headache</td>
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<td>Anorexia / loss of appetite</td>
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<td>Diarrhea</td>
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<td>Vomiting</td>
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<td>Sore throat</td>
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<td>Drowsiness</td>
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<td>Bleeding from any site</td>
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Reviewed by **INFECTION PREVENTION AND CONTROL TEAM**

Approved by **MANUEL T. CHUA CHIACO, M.D.**
INFECTION PREVENTION AND CONTROL

Policy Title

EBOLA VIRUS DISEASE

Date Reviewed

October 2014

Date Revised

October 2014

INFECTION PREVENTION AND CONTROL TEAM

Reviewed by

INFECTION PREVENTION AND CONTROL TEAM

Approved by

MANUEL T. CHUA CHIACO, M.D.
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