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Urgent Care Recommendations for Identification and Isolation of Potential Ebola Patients

The recent *Bundibugyo ebolavirus* outbreak in Central Africa underscores the need for Urgent Care clinicians to remain vigilant and operationally prepared. Although the likelihood of encountering a patient with Ebola disease in the United States is low, Urgent Care centers are often the first point of contact for undifferentiated acute illness. This makes rapid identification, immediate isolation, and safe escalation essential to protect staff, other patients, and the broader community. Frontline teams must be able to recognize epidemiologic risk factors quickly, apply appropriate infection-control measures, and coordinate timely transfer to higher-level care—all while maintaining efficient patient flow and minimizing exposure risk.

Purpose

This document outlines best practices for Urgent Care identification of patients who may have Ebola disease, with emphasis on:

1. Background epidemiology and relevance to U.S. Urgent Care settings.

2. Exposure screening.

3. Recognition of concerning symptoms and signs.

4. Immediate escalation steps.

5. CDC-aligned screening workflow.

6. PPE and preparedness recommendations.

7. Recovery, including disinfection protocols

Background

Urgent Care centers should maintain a low-threshold, structured front-end screening process for possible Ebola disease. Ebola remains rare in the United States, but delayed recognition can place staff, other patients, and the community at risk. The operational goal in Urgent Care is not definitive diagnosis; it is **rapid recognition, immediate isolation, appropriate PPE use, minimization of exposures, and prompt public health notification**.[1][2][3][4][5][6]

Since first recognition in 1976, Ebola outbreaks have largely occurred in sub-Saharan Africa, especially in central, western, and eastern Africa.[5][4] The major modern outbreaks highlight

several risks relevant to Urgent Care operations:

- spread in urban or semi-urban settings

- amplification through population movement and cross-border travel

- transmission during caregiving and funeral practices

- substantial healthcare worker risk

- delayed recognition outside endemic regions due to nonspecific early symptoms[8][5][4]

Areas Affected and U.S. Relevance
Previous Ebola outbreaks have been restricted primarily to African countries, but imported cases have occurred outside Africa, including in the United States and Europe, through infected travelers or returning healthcare workers.[5][4] In the U.S., the practical concern is not high community prevalence; it is **failure to identify a rare imported case early**.

This concern becomes more relevant during periods of high international travel, including travel surges, mission travel, visiting family abroad, humanitarian work, and business travel. Increased travel volume raises the likelihood that Urgent Care centers will evaluate febrile patients soon after return from affected regions. Because early Ebola symptoms overlap with influenza-like illness, malaria, gastroenteritis, COVID-19, and other common syndromes, a **travel-and-exposure question at first contact** remains the key safety intervention.[12][5][2][3]

Transmission and Definition of Exposure
Ebola is transmitted through direct contact with blood or body fluids of a person with symptomatic Ebola disease or a person who has died from Ebola disease, and through contact with contaminated objects or materials. Relevant body fluids include vomit, diarrhea, blood, urine, saliva, sweat, breast milk, amniotic fluid, semen, and other infectious secretions.[7][6] Unlike many other viruses, human-to-human transmission generally occurs after symptom onset, not during the asymptomatic incubation period.[7][6]

For Urgent Care screening, the following patients should be considered at-risk for exposure:

1. **Travel/location exposure**
- Travel within the prior 21 days to an area with a **current or recent Ebola outbreak**, or where public health authorities identify active Ebola transmission risk.[12][1]

- Work or healthcare activity in an Ebola-affected region, especially in clinical, laboratory, burial, or response settings.[13][14]

2. **Personal contact exposure**

- Direct physical contact with a person with suspected or confirmed Ebola disease.

- Contact with blood or body fluids from such a person.

- Handling contaminated clothing, bedding, needles, or medical equipment.

- Living in the same household, sharing transport during illness, or providing hands-on care.

- Participation in funeral or post-mortem rituals involving a person with suspected or confirmed Ebola disease.[15][16][17][12][7][6]

Incubation Period
The incubation period of Ebola virus is **2 to 21 days**, typically around **6 to 10 days**.[5][18][4][6] During the incubation period, exposed individuals are asymptomatic and are not thought to transmit infection.[6] The 21-day interval is therefore the critical screening window for travel and contact history.

Clinical Presentation: What Urgent Care Should Recognize
Ebola usually begins as a **nonspecific acute febrile illness**. Early symptoms often include:

- fever or subjective fever

- severe fatigue or malaise

- myalgias or arthralgias

- headache

- sore throat [5][18][6]

After several days, many patients develop gastrointestinal symptoms, often prominent:

- nausea

- vomiting

- diarrhea

- abdominal pain[5][18][6]

Other concerning findings can include:

- conjunctival injection

- rash, especially maculopapular rash

- cough or dyspnea

- hypotension

- weakness/prostration[5][18][19]

Despite the older term “viral hemorrhagic fever,” bleeding is not required for suspicion and occurs in less than half of patients.[18][4][6] When present, hemorrhagic manifestations usually appear later and may include:

- petechiae or ecchymoses

- gingival bleeding

- epistaxis

- hematemesis

- melena or hematochezia

- conjunctival hemorrhage

- oozing from venipuncture sites or mucosal bleeding[5][18][6][19]

Symptoms or Signs That Should Escalate Care Immediately to Isolation and Health Department Notification

Urgent Care should escalate immediately when a patient has **both**:

1. **Compatible symptoms**, especially fever or recent fever, unexplained severe illness, vomiting, diarrhea, rash, mucosal bleeding, or other concerning systemic illness; and

2. **Relevant travel or exposure within 21 days**.[12][2][3][20]

In practical Urgent Care operations, hemorrhage is not required for diagnosis and not necessary to trigger isolation. The combination of epidemiologic risk and compatible illness is enough to trigger precautions and public health consultation.

CDC-Aligned Screening Recommendations for Urgent Care

Urgent Care centers should follow the CDC recommendations with the "Three I's": Identify, Isolate, and Inform. The following recommendations support this strategy.

Urgent Care screening should be embedded at the earliest possible point of contact: scheduling, digital intake, front desk, or triage.[2][3] A simple screening process is recommended:

Step 1: Ask exposure/travel questions up front

Every patient with fever, gastrointestinal illness, unexplained systemic illness, or hemorrhagic symptoms should be asked:

- Has the patient traveled in the last 21 days to a country or area with a current or recent Ebola outbreak?

- Has the patient had direct contact in the last 21 days with a person known or suspected to have Ebola?

- Has the patient worked in healthcare, laboratory, burial, or humanitarian settings with possible Ebola exposure in the last 21 days?[12][1][13][14][3]

Step 2: Identify compatible symptoms

Screen for:

- fever or history of fever

- severe headache, myalgias, profound fatigue

- vomiting, diarrhea, abdominal pain

- rash

- bleeding or bruising

- conjunctival injection or unexplained severe illness[5][18][6][19]

Step 3: If both epidemiologic risk and compatible illness are present,
- place the patient in a single room with a private bathroom if available

- keep the door closed

- limit staff entry

- avoid moving the patient through common areas unnecessarily

- immediately notify site leadership, infection prevention personnel if available, and the local/state health department for case-specific guidance[1][2][3] (see Appendix for contact information)

Step 4: Minimize exposure-generating activities

- defer nonessential testing and procedures

- avoid aerosol-generating procedures if possible

- if aerosol-generating procedures are unavoidable, use the highest appropriate level of protection and room controls available[1]

Step 5: Coordinate transfer

Urgent Care centers generally should **not** attempt prolonged evaluation or treatment of a suspected Ebola patient on site. Stabilize only as absolutely necessary, coordinate public health, and transfer according to regional protocols and designated receiving-facility pathways.[2][3]

Personal Protective Equipment Recommendations

Urgent Care centers that may evaluate undifferentiated febrile travelers should maintain readily accessible PPE for immediate first-contact management of possible Ebola disease.

For a patient with suspected infection who is clinically stable and does not have bleeding, vomiting, or diarrhea, at minimum, healthcare personnel should wear:

- single-use fluid-resistant gown extending at least to mid-calf, or fluid-resistant coverall

- full face shield

- facemask

- two pairs of disposable examination gloves, with extended cuffs on the outer gloves[1]

For a patient with suspected infection who is clinically unstable or has bleeding, vomiting, or diarrhea, or for a patient with confirmed infection, at minimum healthcare personnel should wear:

- single-use impermeable gown extending at least to mid-calf, or impermeable coverall

- either a PAPR or disposable NIOSH-approved N95 respirator with full face shield and hood

- two pairs of disposable examination gloves with extended-cuff outer gloves

- boot covers extending to at least mid-calf

- disposable apron covering the torso to the level of the mid-calf[1]

Additional PPE program best practices:

- no exposed skin during care of a high-risk patient

- standardized donning and doffing procedures

- use of a trained observer during donning and doffing

- regular staff drills

- clear designation of clean and contaminated zones

- attention to safe specimen handling and regulated waste procedures[21][22]

The following figure shows a representative PPE ensemble for Ebola care:

Figure 1. Personal Protective Equipment for Preventing Exposure to Ebola Virus.

- **Post-Exposure Environmental Decontamination** Isolate and secure affected areas immediately after patient transfer.
- Notify public health and initiate exposure/contact investigation.
- Clean and disinfect all potentially contaminated surfaces using an EPA-registered hospital disinfectant with a non-enveloped virus claim or 0.5% sodium hypochlorite, observing full wet contact time.
- Manage all disposable materials and linens as potentially infectious waste.
- Limit closure to contaminated areas unless broader environmental contamination or operational risk justifies a temporary facility-wide shutdown.
- Reopen once decontamination, waste handling, exposure assessment, and public health/infection prevention review are completed. [23,23]

Operational Best Practices for Urgent Care

Urgent Care centers should adopt the following preparedness measures:

- Maintain a front-end screening script for fever/travel/exposure.

- Update outbreak-area prompts based on current CDC/travel health alerts.

- Post signage instructing symptomatic recent travelers to alert staff immediately.

- Pre-identify an isolation room and route that minimizes contact with others.

- Stock at least a limited Ebola-ready PPE cache for first-contact management.

- Train staff on who to call: medical leadership, infection prevention, local/state health department, and EMS.

- Rehearse a brief "identify-isolate-inform" workflow at regular intervals.[21][1][2][3]

Recommended Screening Language for Intake or Triage

A practical Urgent Care script:

"Within the last 21 days, has the patient:

1. Traveled to an area with a current or recent Ebola outbreak?

2. Had contact with a person known or suspected to have Ebola?

3. Had contact with blood or body fluids of such a person, or participated in caregiving, healthcare, laboratory, or funeral activities involving possible Ebola exposure?"

If yes, ask immediately about:

- fever or recent fever

- vomiting

- diarrhea

- severe weakness

- bleeding/bruising

- severe headache or muscle aches[12][1][2][3][5]

Bottom Line

For Urgent Care centers, the safest approach is simple: **screen early, isolate immediately, protect staff, and notify public health promptly** whenever compatible illness is accompanied by relevant travel or exposure within 21 days. Because Ebola early symptoms

are nonspecific, **travel and exposure history is the critical trigger** for recognition. PPE should be available on site for immediate evaluation, especially during high-travel periods when imported infection risk, although still very low, is more plausible.[1][5][2][3][4][6]

See Appendix for CDC and Local Health Department contact numbers.

See Quick Reference Guide

CDC resources:

Ebola resources for clinicians:

https://www.cdc.gov/ebola/hcp/communication-resources/think-ebola-early-recognition-is-critical-for-infection-control.html

https://www.cdc.gov/ebola/hcp/clinical-guidance/index.html

Updated current Ebola locations and updates:

https://www.cdc.gov/ebola/situation-summary/index.html

Sign up for CDC Weekly Alerts:

https://www.cdc.gov/nchs/updates/index.html

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