ARBOVIRAL INVESTIGATION FORM

PATIENT DEMOGRAPHIC INFORMATION

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

TREATMENT & OUTCOME

Physician Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes, hospital:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __ Age at Onset: _____ ☐days ☐months ☐unknown ☐years

Does the physician feel the patient has WNV/SLE/CVV/La Crosse/EEE/VEE/WEE? (other than arboviral infection) ☐No ☐Unknown ☐Yes

Did patient die as a result of (or complication from) arboviral infection? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Where was the disease acquired? ☐Indigenous (within county) ☐In State (out of county) ☐Out of Country ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Probable ☐Not a Case ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

Select "Yes" only if case meets Confirmed or Probable Case Status: Is this case report published in ArboNET? ☐Yes ☐No

TYPE OF ARBOVIRUS

☐CHIK Chikungunya	☐EEE Eastern Equine Encephalitis	☐Non-LaCrosse California Serogroup†	☐VEE Venezuelan Equine Encephalitis
☐CV Cache Valley	☐JE Japanese Encephalitis	☐POW Powassan	☐WNV West Nile Virus
☐LAC LaCrosse	☐SLE St Louis Encephalitis	☐WEE Western Equine Encephalitis	☐Other Arbovirus

† *California, Jamestown, Canyon, Keystone, Snowshoe hare, & Trivittatus*

GENERAL COMMENTS

_____

_____

_____

SUPERVISOR REVIEW (PHA 4)

Date Due: __ __ / __ __ /__ __ __ __ Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete) ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CLINICAL

Signs & Symptoms

Any reported Fever or Chills? ☐No ☐Unknown ☐Yes

Neuroinvasive Signs & Symptoms (i.e., Encephalitis)

Abnormal neuroimaging:	☐No ☐Unknown ☐Yes	Limb weakness:	☐No ☐Unknown ☐Yes
Acute Flaccid Paralysis (AFP):	☐No ☐Unknown ☐Yes	Aseptic Meningitis:	☐No ☐Unknown ☐Yes
Altered mental status:	☐No ☐Unknown ☐Yes	Stiff neck:	☐No ☐Unknown ☐Yes
Cerebrospinal pleocytosis (↑ wbc):	☐No ☐Unknown ☐Yes	Seizures:	☐No ☐Unknown ☐Yes
Cranial nerve palsy:	☐No ☐Unknown ☐Yes		
Encephalitis:	☐No ☐Unknown ☐Yes		

Non-Neuroinvasive Signs & Symptoms (i.e., West Nile Fever)

Fever:	☐No ☐Unknown ☐Yes	Nausea/Vomiting:	☐No ☐Unknown ☐Yes	Paresis or Paralysis:	☐No ☐Unknown ☐Yes
Headache:	☐No ☐Unknown ☐Yes	Diarrhea:	☐No ☐Unknown ☐Yes	Arthralgia or Arthritis:	☐No ☐Unknown ☐Yes
Rash:	☐No ☐Unknown ☐Yes	Myalgia:	☐No ☐Unknown ☐Yes		

Clinical Syndrome

☐Asymptomatic (i.e., no fever or symptoms) ☐Encephalitis/Meningoencephalitis ☐Other Clinical
☐Uncomplicated Fever ☐Meningitis ☐Unknown

RISK FACTORS

Blood

Was the patient identified by blood donor screening? ☐No ☐Unknown ☐Yes
Has this patient donated blood within **30 days** of illness onset? ☐No ☐Unknown ☐Yes Donation Date: __ __ / __ __ /__ __ __ __
Has this patient received a blood product within **30 days** of illness onset? ☐No ☐Unknown ☐Yes

Organ

Has the patient donated an organ within **30 days** of illness to onset? ☐No ☐Unknown ☐Yes
Has the patient received an organ transplant within **30 days** of illness onset? ☐No ☐Unknown ☐Yes

Infant

Is the patient a breast fed infant/child? ☐No ☐Unknown ☐Yes
Is the patient an infant infected in utero (i.e., mother infected while pregnant)? ☐No ☐Unknown ☐Yes

Occupation

Does the patient work with arboviral agents in a laboratory? ☐No ☐Unknown ☐Yes
Does the patient work in an outside setting? ☐No ☐Unknown ☐Yes Time worked outside: _____hrs/day