

DENGUE INVESTIGATION FORM

PATIENT DEMOGRAPHIC INFORMATION

Name of Person Being Interviewed: _____ Preferred Language: _____
Last Name: _____ First Name: _____ Middle Name: _____
DOB: ___/___/____ Age: _____ years months Sex: Female Male Unknown
Race (**SELECT ALL THAT APPLY**): American Indian/Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander White Unknown
Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Country of Birth: _____
Is the patient deceased? No Unknown Yes Date of Death: ___/___/____
Cause of Death: _____
Street Address 1: _____ Street Address 2: _____
City: _____ State: _____ Zip Code: _____ County: _____
Country of Usual Residence: _____ Dwelling Type: Duplex Mobile Home Multi-unit Office Single Family
Cell Phone: (____) - _____ - _____ Home Phone: (____) - _____ - _____ Work Phone: (____) - _____ - _____
E-mail: _____

INVESTIGATION SUMMARY

Jurisdiction: _____ Investigation Start Date: ___/___/____ Investigation Status: Open Closed
Investigator: _____ Date of Initial Interview Attempt: ___/___/____
Date ADPH Investigator provided patient, or patient representative, with Control Measures: _____
Education of Case/Contact: No Yes Not Applicable
If control measures were not provided, explain: _____

REPORTING SOURCE

Date of Report: ___/___/____ Reporting Source/Type: _____
Reporting Organization: _____ Reporting Provider: _____

TREATMENT & OUTCOME

Physician Name: _____ Phone Number: (____) - _____ - _____ Ext. _____
Was patient hospitalized for this illness? No Unknown Yes If yes, hospital: _____
Admission Date: ___/___/____ Illness Onset Date: ___/___/____ Age at Onset: _____ days months unknown years
Illness Duration: _____ days hours minutes months weeks years unknown
Did the physician feel the patient has WNV/SLE/CVV/LaCrosse/EEE/VEE/WEE? No Unknown Yes
Did patient die as a result of (or complication from) Arboviral infection? No Unknown Yes Date of Death: ___/___/____

CLINICAL

Signs & Symptoms

- Any reported fever: No Unknown Yes
Nausea or Vomiting: No Unknown Yes
Rash: No Unknown Yes
Aches and Pains: No Unknown Yes
Tourniquet test positive: No Unknown Yes
Leukopenia: No Unknown Yes
Abdominal pain or tenderness: No Unknown Yes
Persistent vomiting: No Unknown Yes
Extravascular fluid accumulation: No Unknown Yes
Mucosal bleeding at any site: No Unknown Yes
Liver enlargement > 2 centimeters: No Unknown Yes
Increase hematocrit with rapid decrease in platelet count: No Unknown Yes
Severe plasma leakage: No Unknown Yes
Severe bleeding from gastrointestinal tract or vagina: No Unknown Yes
Severe organ involvement: No Unknown Yes

Clinical Syndrome

- Asymptomatic (i.e., no fever or symptoms) Encephalitis/Meningoencephalitis Unknown
Disease Hepatitis/Jaundice Uncomplicated Fever
Dengue with Hemorrhage Meningitis Multi-System Organ Failure
Dengue Hemorrhagic Fever/Dengue Shock Syndrome Other Clinical: _____

RISK FACTORS

Blood

- Was the patient identified by blood donor screening? No Unknown Yes
Did the patient donate blood within **30 days** of illness onset (or lab collection date)? No Unknown Yes
If Yes, Donation Date: ___ / ___ / _____
Did the patient receive a blood transfusion within **30 days** of illness onset (or lab collection)? No Unknown Yes

Organ

- Did the patient donate an organ(s) within **30 days** of illness onset (or lab collection)? No Unknown Yes
Did the patient receive an organ transplant within **30 days** of illness onset (or lab collection)? No Unknown Yes

Infant

- Is the patient pregnant? No Unknown Yes
Is the patient a breast fed infant/child? No Unknown Yes

Laboratory Exposure

- 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

Exposure and Vaccines

- Has the patient ever had dengue before? No Unknown Yes If yes, when: _____
During the **30 days** prior to onset, did patient get bit by a mosquito? No Unknown Yes
During the **30 days** prior to onset, what is the average number or hours spent outdoors? _____hrs/day
How often is mosquito repellent used during time spent outside? Always Sometimes Never
If mosquito repellent was used, did it contain DEET? No Unknown Yes
Previous arboviral infection? No Unknown Yes
Dengue fever infection? No Unknown Yes
Yellow fever vaccine? No Unknown Yes
Central European encephalitis vaccine? No Unknown Yes
Japanese encephalitis vaccine? No Unknown Yes
Military service? No Unknown Yes

Suspected Transmission Mode:

- Transmission Mode: Vector borne Indeterminate Trans-placental transmission Other
Was the patient infected in utero? No Unknown Yes

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

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): _____

ADDITIONAL COMMENTS

Large empty box for additional comments.