YELLOW FEVER INVESTIGATION FORM

PATIENT INFORMATION

General information

Information as of Date: __ __ / __ __ /__ __ __ __ Interviewee's relation to patient: _____

Other Interviewee's relation to patient: _____

Name of Person Being Interviewed: _____ Preferred Language: _____ Other preferred language: _____

Name information

Name information as of date: __ __ / __ __ /__ __ __ __ First Name: _____ Middle Name:_____

Last Name:_____ Suffix: _____

Other personal details

DOB: __ __ / __ __ /__ __ __ __ Reported Age: ____ Reported Age Units: ☐ Days ☐ Hours ☐ Minutes ☐ Months ☐ Unknown ☐ Weeks ☐ Years

Current Sex: ☐ Female ☐Male ☐ Unknown Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

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

Country of Birth: _____

Primary Occupation: _____Industry: _____

Employer name and Location: _____

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

Reporting address for case counting

Street Address 1: _____ Street Address 2: _____

City: _____ County: _____ State: _____

Zip Code: _____

Dwelling Type: ☐ Duplex ☐ Mobile Home ☐ Multi-unit ☐ Office ☐ Single Family

Telephone information

Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Home Phone: (__ __ __) - __ __ __ - __ __ __ __

Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Email: _____

TYPE OF ARBOVIRUS

Type of Arbovirus: ☐ Alkhuma ☐ Arbovirus ☐ Barmah Forest virus☐ Bourbon virus ☐ Cache Valley virus ☐ Alkhuma ☐ Arbovirus ☐ Barmah Forest virus☐ Bourbon virus ☐ Cache Valley virus ☐California encephalitis virus ☐ Chikungunya virus ☐ Colorado tick fever virus ☐ Dengue virus ☐ Eastern equine encephalitis virus ☐Flavivirus ☐ Heartland virus ☐ Highlands J virus ☐Jamestown Canyon virus ☐ Japanese encephalitis virus ☐ Keystone virus ☐ Kyasanur Forest disease virus ☐ La Crosse virus ☐ Mayaro virus ☐ Murray Valley encephalitis virus ☐ O'nyong-nyong virus ☐ Oropouche virus ☐Powassan virus ☐Rift Valley fever virus ☐Rocio virus ☐ Ross River virus ☐ Saint Louis encephalitis virus ☐ Sindbis virus ☐Snowshoe hare virus ☐Tahyna virus ☐ Tick-borne encephalitis virus ☐Toscana virus ☐Trivittatus virus ☐Usutu virus ☐ Venezuelan equine encephalomyelitis virus ☐ West Nile virus ☐ Western equine encephalomyelitis virus ☐ Yellow fever virus ☐ Zika virus

INVESTIGATION INFORMATION

Investigation Details:

Jurisdiction: _____ Investigation Start Date: __ __ / __ __ /__ __ __ __

Investigation Status: ☐ Open ☐ Closed

Investigator

Investigator: _____ Date Assigned to Investigation: __ __ / __ __ /__ __ __ __

Date of initial interview attempt: __ __ / __ __ /__ __ __ __ Date interview completed: __ __ / __ __ /__ __ __ __

Control measures

Date ADPH investigator provided patient, or patient representative, with control measures: __ __ / __ __ /__ __ __ __

If control measures were not provided, explain: _____

_____

REPORTING INFORMATION

Reporting organization

Earliest Date Reported to Public Health: __ __ / __ __ /__ __ __ __ Reporting source type: _____

Reporting Organization: _____

Reporting provider

Reporting provider: _____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __

TREATMENT & OUTCOME

Physician

Treating Physician: _____

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. ____

Hospital

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

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __

Total duration of stay in the hospital (in days): _____

Condition

Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Illness Duration: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ weeks ☐ years ☐ unknown

Age at Onset: _____ Age at Onset Units: ☐ days ☐ months ☐ years ☐ unknown

Does the physician feel there is a more likely clinical explanation than this arboviral disease?: ☐ No ☐ Yes ☐ Unknown

Did patient die as a result of (or complication from) arboviral infection? ☐ No ☐ Yes ☐ Unknown

CLINICAL

Signs & Symptoms

Fever:	☐ No ☐ Unknown ☐ Yes
Chills or rigors	☐ No ☐ Unknown ☐ Yes
Abdominal pain or tenderness	☐ No ☐ Unknown ☐ Yes
Headache	☐ No ☐ Unknown ☐ Yes
Retro-orbital pain	☐ No ☐ Unknown ☐ Yes
Myalgia	☐ No ☐ Unknown ☐ Yes
Arthralgia	☐ No ☐ Unknown ☐ Yes
Vertigo	☐ No ☐ Unknown ☐ Yes
Conjunctivitis	☐ No ☐ Unknown ☐ Yes
Diarrhea	☐ No ☐ Unknown ☐ Yes
Fatigue or malaise	☐ No ☐ Unknown ☐ Yes
Nausea or Vomiting:	☐ No ☐ Unknown ☐ Yes
Oral ulcer	☐ No ☐ Unknown ☐ Yes
Rash:	☐ No ☐ Unknown ☐ Yes
Acute illness onset:	☐ No ☐ Unknown ☐ Yes

Neuroinvasive Signs and Symptoms

Altered Mental Status	☐ No ☐ Unknown ☐ Yes
Aseptic Meningitis	☐ No ☐ Unknown ☐ Yes
Ataxia	☐ No ☐ Unknown ☐ Yes
Cranial nerve palsy	☐ No ☐ Unknown ☐ Yes
Encephalitis	☐ No ☐ Unknown ☐ Yes
Limb weakness	☐ No ☐ Unknown ☐ Yes
Paralysis or paresis	☐ No ☐ Unknown ☐ Yes
Parkinsonism or cogwheel Rigidity	☐ No ☐ Unknown ☐ Yes
Seizures	☐ No ☐ Unknown ☐ Yes
Stiff Neck	☐ No ☐ Unknown ☐ Yes
Acute Flaccid Paralysis (AFP)	☐ No ☐ Unknown ☐ Yes
Myelitis (inflammation of spinal cord)	☐ No ☐ Unknown ☐ Yes
Peripheral nerve damage	☐ No ☐ Unknown ☐ Yes
Sensory deficit	☐ No ☐ Unknown ☐ Yes
Abnormal reflexes	☐ No ☐ Unknown ☐ Yes

Other Symptoms:

Clinical Syndrome:

☐ Acute flaccid paralysis ☐ Asymptomatic ☐ Congenital Infection ☐ Dengue ☐ Dengue-like illness ☐ Encephalitis - Including Meningoencephalitis ☐ Febrile illness ☐ Guillain Barre syndrome ☐ Hepatitis/Jaundice ☐ Meningitis ☐ Multiple organ failure ☐ Other Clinical ☐ Other Neuroinvasive Presentation ☐ Severe Dengue ☐ Unknown ☐ X - Dengue Hemorrhagic Fever/Dengue Shock Syndrome ☐ X - Dengue with Hemorrhage ☐ X – Disease ☐ X - Uncomplicated Fever

Clinical Syndrome, Secondary:

☐ Acute flaccid paralysis ☐ Encephalitis - Including Meningoencephalitis ☐ Guillain Barre syndrome ☐ Hepatitis/Jaundice ☐ Meningitis ☐ Multiple organ failure ☐ None ☐ Other Clinical ☐ Other Neuroinvasive Presentation

Laboratory Findings

Test Type: _____

Test Result/Interpretation: ☐ Equivocal ☐ Negative ☐ Positive ☐ Test Not Done

Specimen Type: _____
Specimen Collection Date: __ __/__ __/__ __ __ __
Performing Lab Type: ☐ CDC Lab ☐ Commercial Lab ☐ State Public Health Lab

Lab Information:
Cerebrospinal Fluid (CSF) Pleocytosis (>=5 WBC): ☐ No ☐ Yes
Serum Paired Antibody Test Interpretation: ☐ >= 4-fold rise ☐ Negative ☐ Positive ☐ Test Not Done

Epidemiologic

Epi-link
Is this case part of an outbreak: ☐ No ☐ Unknown ☐ Yes
Suspected mode of Arboviral transmission
Transmission Mode: ☐ In-utero (Transplacental) ☐ Indeterminate disease transmission mode ☐ Other ☐ Perinatal exposure ☐ Sexual Transmission ☐ Vector-borne transmission
Was the patient infected in utero: ☐ No ☐ Unknown ☐ Yes
Case status
MMWR Week: __ __MMWR Year: __ __ __ __ Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown
CDC Publish Indicator: ☐Yes ☐ No *Select "Yes" only if case meets Confirmed or Probable Case Status:*
Immediate National Notifiable Condition: ☐ No ☐ Yes ☐ Unknown
Date CDC Was First Verbally Notified of This Case: __ __/__ __/__ __ __ __
Notification Comments to CDC:

Binational Reporting (Check all that apply)
☐Exposure to suspected product from Canada or Mexico
☐Has case contacts in or from Mexico or Canada
☐Other situations that may require binational notification or coordination of response
☐Potentially exposed by a resident of Mexico or Canada
☐Potentially exposed while in Mexico or Canada
☐Resident of Canada or Mexico

SUPERVISOR REVIEW (PHA 4)

Date Due to Jefferson County Supervisor __ __ / __ __ /__ __ __ __
Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐ Yes
Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __
Review comments (completed by Jefferson County supervisor):

GENERAL COMMENTS

RISK FACTORS

Blood
Identified by blood donor screening? ☐ No ☐ Unknown ☐ Yes
Did patient donate blood within 30 days before/after illness onset (or lab collection)? ☐ No ☐ Unknown ☐ Yes
Date of Donation or collection Date (if applicable): __ __ / __ __ /__ __ __ __
Blood transfusion received within 30 days prior to illness onset (or lab collection): ☐ No ☐ Unknown ☐ Yes

Organ

Did patient donate an organ(s) within 30 days before/after illness onset (or lab collection)? ☐ No ☐ Unknown ☐ Yes

Was an organ transplant received within 30 days prior to illness onset (or lab collection)? ☐ No ☐ Unknown ☐ Yes

Potential mother-to-infant transmission

Is the patient pregnant? ☐ No ☐ Unknown ☐ Yes

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

Mother's Last Menstrual Period Before Delivery: __ __/__ __/__ __ __ __

Occupational exposure

Does the patient work with arboviral agents in a laboratory? ☐ No ☐ Unknown ☐ Yes

Does the patient work in an outdoor setting? ☐ No ☐ Unknown ☐ Yes

Exposure and vaccines

During the 30 days prior to onset, what is the average number of hours spent outside (hrs/day)?: _____

During the 30 days prior to onset, did patient get bit by a mosquito? ☐ No ☐ Unknown ☐ Yes

How often is mosquito repellent used during time spent outside? ☐ Always ☐ Never ☐ Sometimes

If mosquito repellent was used, did it contain DEET? ☐ No ☐ Unknown ☐ Yes

Previous arboviral 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

Is this case epi-linked to a laboratory probable or confirmed case: ☐ No ☐ Unknown ☐ Yes

TRAVEL HISTORY

Travel

Did the patient travel outside of country jurisdiction prior to illness onset: ☐ No ☐ Unknown ☐ Yes

If answer yes: What was the purpose of travel?: ☐ Business ☐ Immigration to US ☐ Tourism

☐ Visiting Relatives/Friends ☐ Other If other purpose specify:_____

_____

_____

Type of Destination 1: ☐ Domestic ☐ International

Mode Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise Ship ☐ Train

Arrival Date: __ __/__ __/__ __ __ __

Departure Date: __ __/__ __/__ __ __ __

Type of Destination 2: ☐ Domestic ☐ International

Mode Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise Ship ☐ Train

Arrival Date: __ __/__ __/__ __ __ __

Departure Date: __ __/__ __/__ __ __ __

Type of Destination 3: ☐ Domestic ☐ International

Mode Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise Ship ☐ Train

Arrival Date: __ __/__ __/__ __ __ __

Departure Date: __ __/__ __/__ __ __ __

If more than 3 destinations, specify details here:

_____

_____

Disease acquisition

Where was the disease acquired: ☐ Imported, but not able to determine source state and/or country ☐ In state, out of jurisdiction ☐ Indigenous ☐ International ☐ Out of state ☐ Unknown

READ ONLY – Enter Current Travel Data Under Exposures Tab

Read Only – History of Travel

Travel history entered prior to the addition of the repeating block.

Date of Return from Travel: __ __/__ __/__ __ __ __

Destination(s) of travel (city, county, state, country: _____

_____

Departure Date: __ __/__ __/__ __ __ __

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise Ship ☐ Train