

Arboviral Case Investigation

- West Nile St. Louis
 Chikungunya Zika
 Other Arbovirus: _____

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

Patient Information

Last Name: _____ First Name _____
 Date of Birth: ____/____/____ Sex: Male Female Unknown
 Street Address: _____ City, State, Zip: _____
 Patient Phone: _____ County of Residence: _____
 Race: Asian American Indian/Alaskan Native
 Black or African American Native Hawaiian/Pacific Islander
 White Unknown Other: _____
 Ethnicity: Hispanic Not Hispanic Unknown

Clinical Information

Physician: _____ Address _____
 City, State, Zip: _____ Phone: _____ Fax: _____
 Was the patient hospitalized for this illness? Yes No Unknown
 If yes, provide name of hospital: _____
 Dates of hospitalization: Admission ____/____/____ Discharge ____/____/____
 Date of Illness Onset: ____/____/____
 Is the patient deceased? Yes No Unknown
 If yes, provide date of death: _____ (submit documentation if due to arbovirus)

Clinical Evidence

<u>Non-neurological Evidence:</u>	<u>Neurological Evidence (indicated in medical record):</u>
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Altered taste <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Chills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Abnormal reflexes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Nerve palsies <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Ataxia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute flaccid paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Retro-orbital pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Altered mental state <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Severe malaise <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Confusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Nausea/Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Stiff neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CSF pleocytosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle weakness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Myelitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Myalgia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Demyelinating neuropathy (including Guillain-Barré Syndrome) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Joint/Bone Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Neuritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Vertigo <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Congenital Evidence (indicated in medical record; check all that apply):

Microcephaly Intracranial calcifications Ophthalmologic abnormality
 Other CNS abnormality - describe: _____

Does the patient have an underlying chronic illness? Yes No Unknown
 Is the patient immunosuppressed? Yes No Unknown
 Is there a more likely clinical explanation for the patient's symptoms? Yes No Unknown

Clinical Syndrome: Uncomplicated Fever Encephalitis Meningitis Other Neurological Illness

NBS Patient ID: _____

Patient Name: _____

Epidemiology

In the 30 days prior to onset, did the patient donate/receive: Blood Blood Product Organ/Tissue
If yes, date donated: _____ Blood Collection Agency: _____
If yes, date blood, organ, or tissue received: _____ Medical Facility: _____

Was the patient pregnant during illness? Yes No Unknown N/A
If yes, was there Fetal loss In utero evidence of fetal abnormality Normal outcome Unknown

Was the patient breastfeeding within 2 weeks of onset? Yes No Unknown N/A

Occupation: _____
(give exact job, type of business or industry, work shift and % of time spent outside while at work)

Average number of hours spent outdoors each day (in 30 days prior to onset): <2 2-4 5-8 >8

When outdoors, what percentage of the time did the patient use mosquito repellent?
 Always 75% 50% 25% Never

Did the patient travel outside of their residence County within 15 days of illness onset?
 Yes No Unknown
If yes, provide dates and locations on page 3.

Is case thought to be imported? Yes No Unknown
If yes, from where: _____

Does the patient know anyone else experiencing a similar illness? Yes No Unknown
If yes, provide names and contact information on page 3

Case acquired (circle one): *Provide details, names, contact information, etc. on page 3*
Vector Sexual Transplantation Transfusion Transplacental Breastfeeding Lab-Acquired Unknown

For Zika and Chikungunya Only:

Was the patient viremic while in Texas (during 7 days after onset)? Yes No Unknown
If yes, provide dates and locations where the patient may have been bitten by mosquitoes on page 3.

Laboratory Findings

Test	Date Collected	Source	Result	Interpretation
				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done
				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done
				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done
				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done
Organism Identification	Date Collected	Source	Result	Interpretation
				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done

Comments or Other Pertinent Epidemiological Data *(Use page 3 if necessary):*

Date First Reported: ___/___/___ Investigation: Started ___/___/___ Completed ___/___/___
Reporting Facility: _____
Name of Investigator: _____ *(Please print clearly)*
Agency: _____ *(Please do not abbreviate)*
Phone: _____ E-Mail: _____

NBS Patient ID: _____

Patient Name: _____

Travel Dates and Locations Prior to Illness Onset

Dates	Area/Street Address	City	State	Country

Other Persons Experiencing Similar Illness

Name	Telephone Number	Street Address	City	State

Locations of Possible Mosquito Exposure While Viremic

Estimated dates of viremia: from ___/___/___ to ___/___/___

Date(s)	Street Address	City	County	Comments

Additional Comments or Other Pertinent Epidemiological Data: