TEXAS Health and Human Services | Texas Department of State Health Services

Animal Arboviral Disease Report

☐ Eastern Equine Encephalitis Virus
☐ Western Equine Encephalitis Virus
☐ West Nile Virus
☐ Other Arbovirus_____

PLEASE PRINT LEGIBLY

Animal Information

DSHS Case #: _____ Animal's Name: _____
Species: _____ Sex: ☐ Male ☐ Female ☐ Unknown
Age: _____ Neutered: ☐ Yes ☐ No ☐ Unknown
Animal's Location (Address, City, Zip): _____
County of Residence: _____ Longitude: _____ Latitude: _____

Contact Information

Owner's Name: _____ Cell Phone: _____
Owner's Address: _____ Other Phone: _____
City, State, Zip: _____ County: _____
Veterinarian: _____ Phone:_____ Fax:_____
Clinic Name: _____ Email: _____
Address: _____ City, State, Zip: _____

Clinical Information

Date of Illness Onset ____/____/_____

Fever _____°F	☐ Yes	☐ No	☐ Unknown
Anxiety	☐ Yes	☐ No	☐ Unknown
Lameness	☐ Yes	☐ No	☐ Unknown
Impaired vision	☐ Yes	☐ No	☐ Unknown
Muzzle twitching	☐ Yes	☐ No	☐ Unknown
Trembling	☐ Yes	☐ No	☐ Unknown
Inability to swallow	☐ Yes	☐ No	☐ Unknown
Facial/lip paralysis	☐ Yes	☐ No	☐ Unknown

Inability to rise/stand	☐ Yes	☐ No	☐ Unknown
Incoordination/ataxia	☐ Yes	☐ No	☐ Unknown
Irregular gait	☐ Yes	☐ No	☐ Unknown
Weakness	☐ Yes	☐ No	☐ Unknown
Muscle Contractions	☐ Yes	☐ No	☐ Unknown
Paralysis	☐ Yes	☐ No	☐ Unknown
Convulsions	☐ Yes	☐ No	☐ Unknown
Died or euthanized	☐ Yes	☐ No	☐ Unknown

Date of Death ___/ ___/ ____

Epidemiology

Did the patient travel outside of County in the 15 days prior to illness onset? ☐ Yes ☐ No ☐ Unknown
If yes, provide date of travel and locations: _____
Is case thought to be imported from outside of Texas? ☐ Yes ☐ No ☐ Unknown
If yes, from where: _____
For equines, please indicate the dates the patient was vaccinated for each arbovirus:

Vaccine	Date Administered	Vaccine	Date Administered
WNV		WEE	
EEE		VEE	

Laboratory Findings

Test	Date Collected	Source	Result	Interpretation
				☐ Positive ☐ Negative ☐ Not Done
				☐ Positive ☐ Negative ☐ Not Done
				☐ Positive ☐ Negative ☐ Not Done
				☐ Positive ☐ Negative ☐ Not Done

Completed by Investigating Agency

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