



Dengue Case Investigation

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

Confirmed Probable Suspect

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

Fever Yes No Unknown Leukopenia (total white blood cell count <5,000mm³)* Yes No Unknown
Chills Yes No Unknown Extravasacular fluid accumulation Yes No Unknown
Headache Yes No Unknown Positive tourniquet test* Yes No Unknown
Retro-orbital pain Yes No Unknown Mucosal bleeding Yes No Unknown
Nausea/Vomiting Yes No Unknown Liver enlargement (> 2 cm)* Yes No Unknown
Myalgia Yes No Unknown Thrombocytopenia (platelet count <150/000mm³)* Yes No Unknown
Joint/bone pain Yes No Unknown
Rash Yes No Unknown
Abdominal pain Yes No Unknown
Increasing hematocrit (>20% in 2 measurements taken 6+ hours apart)* Yes No Unknown

*Symptoms must be documented in the medical records, not self-reported by the patient

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Clinical Evidence (continued)

Severe Dengue Clinical Evidence*

Severe plasma leakage characterized by shock **OR** by extravascular fluid accumulation with respiratory distress. Yes No Unknown

Severe bleeding defined as one or more of the following: Bleeding that results in hemodynamic instability or blood transfusion (except platelets) **OR** in permanent disability **OR** bleeding classified as severe by a clinical provider. Yes No Unknown

Severe organ involvement including myocarditis, cholecystitis, pancreatitis, brain (including diagnosis of encephalitis, encephalopathy, or meningitis), liver (including elevated liver transaminases >1,000 units per liter), or other organ. Yes No Unknown

Elevated liver transaminases: aspartate aminotransferase (AST) or alanine aminotransferase (ALT) **>1,000 units per liter** (U/L). Yes No Unknown

Impaired level of consciousness (i.e. encephalitis or encephalopathy). Yes No Unknown

Epidemiology

Did the patient donate or receive blood, blood products, or organ/tissue in 30 days before or after onset?

Yes – Donate Yes – Receive (Transfusion/Transplant) No Unknown

If yes: Type of product: Blood Blood products Organ/tissue

Donation date(s): ___/___/___ ; ___/___/___ ; ___/___/___

Transfusion/transplant date(s): ___/___/___ ; ___/___/___ ; ___/___/___

Blood Collection Agency/Medical Facility: _____

Does this patient have a recent vaccination against a flavivirus (e.g. Yellow fever or Japanese encephalitis)? Yes No Unknown

Was the patient pregnant during illness? Yes No Unknown N/A

For infant patients only: Was the patient consuming breastmilk 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)

In the 30 days prior to onset, how many hours did the patient spend outdoors each day? <2 2-4 5-8 >8 Unknown

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

Did the patient travel outside of their residence county within 15 days of illness onset? Yes No Unknown

If yes, provide:

Dates of travel: _____

Locations of travel: _____

Where was the disease acquired?

- Indigenous International In State, Out of Jurisdiction Out of State (includes U.S. territories)
- Imported, but not able to determine source state and/or county Unknown

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

Transmission Mode: Vector-borne In-Utero (transplacental) Perinatal Blood-borne
 Indeterminate Other (explain): _____

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 Type (IgM, IgG, PCR, NS1, or PRNT)	Date Collected	Performing Lab Name	Specimen Type	Result	Interpretation
					<input type="checkbox"/> Pos <input type="checkbox"/> Equiv <input type="checkbox"/> Neg
					<input type="checkbox"/> Pos <input type="checkbox"/> Equiv <input type="checkbox"/> Neg
					<input type="checkbox"/> Pos <input type="checkbox"/> Equiv <input type="checkbox"/> Neg
					<input type="checkbox"/> Pos <input type="checkbox"/> Equiv <input type="checkbox"/> Neg

Comments or Other Pertinent Epidemiological Data:

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

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