



Do not use for West Nile virus disease

LHJ Use ID
Reported to DOH Date
LHJ Classification Confirmed Probable
By: Lab Clinical Epi Link

Outbreak-related
LHJ Cluster#
LHJ Cluster Name:
DOH Outbreak #

Arboviral Disease

County
REPORT SOURCE

LHJ notification date
Reporter (check all that apply)
Lab Hospital HCP
Public health agency Other
OK to talk to case? Yes No Don't know

Investigation start date:

Reporter name
Reporter phone
Primary HCP name
Primary HCP phone

PATIENT INFORMATION

Name (last, first)
Address
City/State/Zip
Phone(s)/Email
Alt. contact Parent/guardian Spouse Other Name:
Zip code (school or occupation): Phone:
Occupation/grade
Employer/worksite School/child care name

Birth date Age
Gender F M Other Unk
Ethnicity Hispanic or Latino Not Hispanic or Latino
Race (check all that apply)
Amer Ind/AK Native Asian
Native HI/other PI Black/Afr Amer
White Other

CLINICAL INFORMATION

Onset date: Derived Diagnosis date: Illness duration: days

Signs and Symptoms

Type of arboviral disease (Do not use this form for WNV)

- Western Equine Encephalitis Eastern Equine Encephalitis
St. Louis Encephalitis Japanese Encephalitis
Dengue Fever LaCrosse
Other:

- Fever Highest measured temp: Type: Oral Rectal Other: Unk
Nausea Vomiting Headache Stiff neck
Eyes sensitive to light (photophobia) Confusion
Muscle aches or pain (myalgia) Joint pain
Seizures new with disease Rash

Clinical Findings (cont'd)

- Y N DK NA
Complications, specify:
Admitted to intensive care unit

Hospitalization

- Y N DK NA
Hospitalized for this illness
Hospital name Admit date Discharge date
Y N DK NA
Died from illness Death date
Autopsy Place of death

Vaccinations

- Y N DK NA
Japanese encephalitis or yellow fever vaccine in past Type: Date

Predisposing Conditions

- Y N DK NA
Previous flavivirus infection (e.g., dengue, SLE)

Clinical Findings

- Y N DK NA
Neurological abnormalities:
Altered mental status Ataxia
Paralysis or weakness Rash observed by health care provider
Lymphadenopathy Arthritis or arthralgia
Meningitis Encephalitis or encephalomyelitis
Jaundice Liver abnormality or failure
Kidney (renal) abnormality or failure Hemorrhagic signs

Laboratory

- Specimen type Collection date
Specimen type Collection date
P N I O NT
Abnormal CSF Profile: wbc (% lymph % neutr) rbc prot gluc
Viral antibodies with single elevated titer or <= 2-fold increase or virus-specific IgM by EIA without IgG confirmation (serum) [Probable]
Viral IgM by EIA (CSF)
Viral antibodies with >= 4-fold rise (serum pair)
Viral IgM by EIA and IgG by another assay (e.g., PRNT) (serum or CSF)
Virus culture or PCR (clinical specimen)

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

Exposure period

Days from onset: -15 -2

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

- Travel out of the state, out of the country, or outside of usual routine
Out of: County State Country
Dates/Locations: _____
- Case knows anyone else with similar symptoms
- Insect or tick bite
 - Mosquito Tick
 - Other: _____
 - Unknown insect or tick type
- Location of insect or tick exposure: _____
- Date of exposure: ___/___/___

Y N DK NA

- Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
- Blood transfusion or blood products (e.g. IG, factor concentrates)
Date of receipt: ___/___/___
- Organ or tissue transplant recipient
Date of receipt: ___/___/___
- If infant, birth mother had febrile illness
- If infant, infected in utero
- If infant, breast fed
- Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____
- Occupational exposure
Lab worker Y N DK NA
Other: _____

Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PUBLIC HEALTH ISSUES

Y N DK NA

- Neonatal
Delivery location: _____
- Pregnant
Estimated delivery date ___/___/___
OB name, address, phone: _____
- Did case donate blood products in the 30 days before symptom onset Date: ___/___/___
Agency and location: _____
Specify type of donation: _____
- Did case donate organs or tissue (including ova or semen) in the 30 days before symptom onset
Date: ___/___/___
Agency and location: _____
Specify type of donation: _____

PUBLIC HEALTH ACTIONS

- Breastfeeding education provided
- Notify blood or tissue bank
- Other, specify: _____

NOTES

Investigator _____ Phone/email _____ Investigation complete date ___/___/___

Local health jurisdiction _____