Do not use for West Nile Virus disease or Yellow Fever

Arboviral Disease

County

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 # ______

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
Reporter (check all that apply) ☐ Lab ☐ Hospital ☐ HCP ☐ Public health agency ☐ Other
OK to talk to case? ☐Yes ☐No ☐DK Date of interview ___/___/___

Reporter name ______
Reporter phone ______
Primary HCP name ______
Primary HCP phone ______

PATIENT INFORMATION

Name (last, first) ______
Address ______ ☐ Homeless
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 ☐ Unk
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other ☐ Unk

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Type of arboviral disease: *(Record in species/organism in PHIMS)*
☐ Western equine encephalitis ☐ Eastern equine encephalitis
☐ St. Louis encephalitis ☐ Japanese encephalitis
☐ Dengue ☐ LaCrosse encephalitis
☐ Other: ______ *Do not use this form for WNV or Yellow fever*

Signs and Symptoms
Y N DK NA
☐ ☐ ☐ ☐ **Fever** # days:____ Highest meas'd temp:______°F
☐ ☐ ☐ ☐ Nausea or vomiting
☐ ☐ ☐ ☐ **Headache**
☐ ☐ ☐ ☐ **Stiff neck**
☐ ☐ ☐ ☐ Eyes sensitive to light (photophobia)
☐ ☐ ☐ ☐ Muscle aches or pain (myalgia)
☐ ☐ ☐ ☐ Joint pain (arthralgia)
☐ ☐ ☐ ☐ Rash

Predisposing Conditions
☐ ☐ ☐ ☐ Previous flavivirus infection (e.g., dengue, SLE)
☐ ☐ ☐ ☐ Underlying chronic illness or immunosuppressed

Clinical Findings
Y N DK NA
☐ ☐ ☐ ☐ Rash observed by health care provider
☐ ☐ ☐ ☐ Arthritis
☐ ☐ ☐ ☐ Jaundice or hepatitis
☐ ☐ ☐ ☐ Kidney (renal) abnormality or failure
☐ ☐ ☐ ☐ Multiple organ failure
☐ ☐ ☐ ☐ **Acute flaccid paralysis (neuroinvasive)**
☐ ☐ ☐ ☐ **Other neuroinvasive**:
☐ Altered mental status (disorientation, stupor)
☐ Meningitis ☐ Encephalitis / meningoencephalitis
☐ Limb weakness (documented by HCP)
☐ Ataxia ☐ Abnormal reflexes ☐ Seizures (new)
☐ Paresis ☐ Other acute abnormality:______
☐ ☐ ☐ ☐ **Hemorrhagic signs**: ☐ Positive tourniquet test
☐ Petechiae ☐ Purpura/ecchymosis ☐ Epistaxis
☐ Gum bleeding ☐ Blood in vomitus, stool, urine
☐ Vaginal bleeding ☐ Nasal bleeding ☐+ urinalysis
☐ ☐ ☐ ☐ **Plasma leakage or pleural effusion or ascites**
☐ ☐ ☐ ☐ **Shock syndrome** (hypotension, clammy skin, rapid pulse)
☐ ☐ ☐ ☐ Complications, specify: ______
☐ ☐ ☐ ☐ Admitted to intensive care unit

Hospitalization
Y N DK NA
☐ ☐ ☐ ☐ Hospitalized at least overnight for this illness
Hospital name ______
Admit date ___/___/____ Discharge date ___/___/____
☐ ☐ ☐ ☐ Died from illness Death date ___/___/____
☐ ☐ ☐ ☐ Autopsy Place of death ______

Vaccinations
Y N DK NA
☐ ☐ ☐ ☐ Japanese encephalitis or yellow fever vaccine in past Type: ______ Date ___/___/___

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

Specimen type ______ Specimen type ______
Collection date ___/___/___ Collection date ___/___/___

P N I O NT
☐ ☐ ☐ ☐ ☐ **Thrombocytopenia** (<100K platelets/mm^3)
☐ ☐ ☐ ☐ ☐ Abnormal CSF profile: wbc ____ (% lymph____; % neutr____) rbc ____ prot ____ gluc ____
☐ ☐ ☐ ☐ ☐ **Pleocytosis** (increased WBC in CSF)

Dengue-specific labs
☐ ☐ ☐ ☐ ☐ **Dengue: IgM + (P/N >2)** (single serum) **[Probable]**
☐ ☐ ☐ ☐ ☐ **Dengue: Viral culture or PCR** (clinical specimen)
☐ ☐ ☐ ☐ ☐ **Dengue: IgM seroconversion** (acute <5 d; conv ≥5 d)
☐ ☐ ☐ ☐ ☐ **Dengue: IgG with ≥ 4-fold rise** (serum pair)
☐ ☐ ☐ ☐ ☐ **Dengue: ≥4-fold difference between dengue and other flaviviruses by PRNT** (single conv. serum)
☐ ☐ ☐ ☐ ☐ **Dengue: IgM in CSF**

Other arbovirus labs
☐ ☐ ☐ ☐ ☐ **Other: IgM in serum by EIA/MIA/IFA [Probable]**
☐ ☐ ☐ ☐ ☐ **Other: IgM in CSF by EIA/MIA/IFA [Probable]**
☐ ☐ ☐ ☐ ☐ **Other: Virus culture or PCR** (clinical specimen)
☐ ☐ ☐ ☐ ☐ **Other: ≥4-fold rise in quantitative titer** (serum pair)
☐ ☐ ☐ ☐ ☐ **Other: IgM in serum with confirmatory assay (e.g., PRNT) in same or later specimen**
☐ ☐ ☐ ☐ ☐ **Other: Virus-specific IgM in CSF and negative IgM result for other arboviruses**

Tested at: ☐ WA PHL ☐ CDC ☐ Other PHL ☐ Commercial ☐ Other

INFECTION TIMELINE

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

	Exposure period		onset
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

☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed case** *(only applies to Dengue; for Suspect case definition)*
☐ Travel to dengue endemic country
☐ Association in time and place with another case

☐ ☐ ☐ ☐ 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: ___/___/___

☐ ☐ ☐ ☐ Infant
☐ Birth mother had febrile illness
☐ Infected in utero
☐ 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 ______________________