



DENGUE CASE INVESTIGATION REPORT

CDC Dengue Branch and Puerto Rico Department of Health
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Form Approved OMB No. 0920-0009

FOR CDC DENGUE BRANCH USE ONLY

Case number	Specimen #	Days post onset (DPO)	Type	Date Received	Specimen #	Days post onset (DPO)	Type	Date Received
<input type="text"/>	S1	___/___/___		___/___/___	S3	___/___/___		___/___/___
SAN ID	GCODE	S2		___/___/___	S4	___/___/___		___/___/___

Please complete all sections

Hospitalized: <input type="checkbox"/> No <input type="checkbox"/> Yes → Hospital Name: _____	Fatal: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK
Name of Patient: _____ Last Name First Name Middle Name or Initial	Mental Status Changes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK
If patient is a minor, name of father or primary caregiver: _____ Last Name First Name Middle Name or Initial	

Home Address

City, Town: _____ Barrio: _____

Urbanization or sector: _____

Street: _____ House / Apt. Number: _____

Premise No.: _____ Box: _____ P.O. Box: _____

Road No.: _____ Km: _____ Hm: _____ Tel: _____ Other Tel: _____

Residence is close to: _____ Zip Code: _____

Work address: _____

Physician who referred the case

Name of Healthcare Provider: _____

Phone number: _____ Email address: _____

Send laboratory results to: _____

Patient's Basic Information

Date of Birth: _____ Age: _____ months Sex: M F
Day / Month / Year OR _____ years

Information about the person filling out this form

Name and title: _____ Phone number: _____

Name and address of employment: _____

Must have the following information for sample processing

Date of first symptom: _____ Day / Month / Year

Date specimen taken: _____

Serum: **First sample** (Acute = first 5 days of illness - check for virus) _____ Day / Month / Year

Second sample (Convalescent = more than 5 days after onset - check for antibodies) _____ Day / Month / Year

Third sample _____ Day / Month / Year

Tissue for fatal cases (specify): _____ Day / Month / Year

Additional Data

- How long have you lived in this city? _____
- Country of birth: _____
- Have you been diagnosed with dengue before? Yes No UNK
- When diagnosed? _____ / _____
Month Year UNK
- During the 14 days before onset of illness, did you TRAVEL to other cities or countries? Yes, another country Yes, another city No UNK
- WHERE did you TRAVEL? _____

Criteria for DENGUE HEMORRHAGIC FEVER (#1 4) and shock (#5)

	Yes	No	UNK		Yes	No	UNK		Yes	No	UNK		
1. Fever (>38°C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tourniquet test <input type="checkbox"/> Not done <input type="checkbox"/> Pos <input type="checkbox"/> Neg	Symptoms continued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Platelets ≤100,000/mm3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Evidence of capillary leak	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pleur or abdominal effusion <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Any hemorrhagic manifestation				Lowest hematocrit _____	Pallor or cool skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest hematocrit _____	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Petechiae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Highest hematocrit _____	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest serum albumin _____	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purpura/Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest serum protein _____	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Lowest blood pressure _____ / _____	Conjunctivitis (red eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomit with blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest pulse pressure _____	Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(systolic minus diastolic) _____	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest white blood cell count _____	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other symptoms	Convulsion or coma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes No UNK	Got Yellow Fever Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	Year vaccinated _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Positive urinalysis (over 5 RBC/hpf or positive for blood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

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Specimen No.

S¹ _____ S² _____ S³ _____

**SEROLOGY
LUMINEX (MIA)**

S ¹			S ²			S ³		
Test Date	Ag	Titer	Test Date	Ag	Titer	Test Date	Ag	Titer

IgG ELISA

S ¹				S ²				S ³			
Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer

IgM ELISA

S ¹			S ²			S ³		
Test Date	Ag	Value	Test Date	Ag	Value	Test Date	Ag	Value

Neutralization

S ¹			S ²			S ³		
Test Date	Screen	Titer	Test Date	Screen	Titer	Test Date	Screen	Titer
DENV-1								
DENV-2								
DENV-3								
DENV-4								
WEST NILE								
SLE								
YFV								

Viral Isolation & PCR

S ¹				S ²				S ³			
Test Date	ID	Isotech	IDtech	Test Date	ID	Isotech	IDtech	Test Date	ID	Isotech	IDtech

Serology Lab Director Signature: _____

Virology Lab Director Signature: _____ Overall dengue interpretation: _____

This questionnaire is authorized by law (Public Health Service Act 42 USC 241). Although response to the questions asked is voluntary, cooperation of the patient is necessary for the study and control of the disease. Public reporting burden for the collection of information is estimated to average 15 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to PHS Reports Clearance Officer, Rm. 721-H, Humphrey Bg, 200 Independence Ave., SW, Washington, DC 20201; ATTN: PRA, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC.