

Today's date: ___/___/___
Day Month Year



DENGUE CASE INVESTIGATION REPORT (HAITI TRAVEL)

CDC Dengue Branch and Puerto Rico Department of Health

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Form Approved OMB No. 0920-

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 read and complete ALL sections

Patient Data Hospitalized due to this illness: No Yes → Hospital Name: _____ Civilian: DoD:

Name of Patient: Last Name _____ First Name _____ Middle Name or Initial _____
 If patient is a minor, name of father or primary caregiver: Last Name _____ First Name _____ Middle Name or Initial _____
 Fatal: Yes No Unk
 Mental status changes: Yes No Unk

Home (Physical) Address	Physician who referred this case
City: _____ Zip code: _____ - _____	Name of Healthcare Provider: _____
Tel: _____ Other Tel: _____	Tel: _____ Fax: _____ Email: _____
Residence is close to: _____	Send laboratory results to (mailing address): _____
Work address: _____	

Patient's Demographic Information	Who filled out this form?
Date of Birth: ___/___/___ Age: ___ month Sex: <input type="checkbox"/> M <input type="checkbox"/> F or Age: ___ years Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK Day Month Year Weeks pregnant (gestation): _____	Name (complete) _____ Relationship with patient: _____ Tel: _____ Fax: _____ Email: _____

Must have the following information for sample processing	Additional Patient Data
Date of first symptom: ___/___/___ Date specimen taken: ___/___/___ Serum: First sample (Acute = first 5 days of illness - check for virus) ___/___/___ Second sample (Convalescent = more than 5 days after onset - check for antibodies) ___/___/___ Third sample ___/___/___ Fatal cases (tissue type): ___/___/___	How long have you lived in this city? _____ Country of birth _____ Have you been diagnosed with dengue before? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk When diagnosed? ___/___/___ Got Yellow Fever Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Year vaccinated _____ During the 14 days before onset of illness, did you TRAVEL to other cities or countries? <input type="checkbox"/> Yes, another country <input type="checkbox"/> Yes, another city <input type="checkbox"/> No <input type="checkbox"/> Unk WHERE did you TRAVEL? _____

PLEASE indicate below the signs and symptoms that the patient has at the time that this form is being completed

	Yes	No	Unk		Yes	No	Unk
Fever lasting 2-7 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of capillary leak			
Fever now (>38°C).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest hematocrit (%) _____			
Platelets ≤100,000/mm ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Highest hematocrit (%) _____			
Platelet count: _____				Lowest serum albumin _____			
Any hemorrhagic manifestation				Lowest serum protein _____			
Petechiae.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest blood pressure (SBP/DBP) _____/____			
Purpura/Ecchymosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest pulse pressure (systolic - diastolic) _____			
Vomit with blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest white blood cell count (WBC) _____			
Blood in stool.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms	Yes	No	Unk
Nasal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid, weak pulse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pallor or cool skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive urinalysis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(over 5 RBC/hpf or positive for blood)				Eye pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tourniquet test <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done				Body (muscle/bone) pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Joint pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Anorexia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Warning signs			
				Persistent vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Abdominal pain/Tenderness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Mucosal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Lethargy, restlessness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Liver enlargement >2cm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Pleural or abdominal effusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Additional symptoms			
				Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Conjunctivitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Nasal congestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Convulsion or coma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Nausea and vomiting (occasional).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Arthritis (Swollen joints).....	<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	P/N	Test Date	Ag	P/N	Test Date	Ag	P/N

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.