DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Arboviral Case Investigation

☐ West Nile ☐ St. Louis
☐ Chikungunya
☐ Other Arbovirus: _____

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

Non-neurological Evidence:				Neurological Evidence (indicated in medical record):			
Fever	☐ Yes	☐ No	☐ Unknown	Altered taste	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown	Abnormal reflexes	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown	Nerve palsies	☐ Yes	☐ No	☐ Unknown
Anorexia	☐ Yes	☐ No	☐ Unknown	Ataxia	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown	Acute flaccid paralysis	☐ Yes	☐ No	☐ Unknown
Retro-orbital pain	☐ Yes	☐ No	☐ Unknown	Altered mental state	☐ Yes	☐ No	☐ Unknown
Severe malaise	☐ Yes	☐ No	☐ Unknown	Confusion	☐ Yes	☐ No	☐ Unknown
Nausea/Vomiting	☐ Yes	☐ No	☐ Unknown	Seizures	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown	Paralysis	☐ Yes	☐ No	☐ Unknown
Stiff neck	☐ Yes	☐ No	☐ Unknown	CSF pleocytosis	☐ Yes	☐ No	☐ Unknown
Muscle weakness	☐ Yes	☐ No	☐ Unknown	Myelitis	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown	Demyelinating neuropathy (including Guillain-Barré Syndrome)	☐ Yes	☐ No	☐ Unknown
Joint/Bone Pain	☐ Yes	☐ No	☐ Unknown				
Rash	☐ Yes	☐ No	☐ Unknown	Neuritis	☐ Yes	☐ No	☐ Unknown
Vertigo	☐ Yes	☐ No	☐ Unknown				

Is the patient pregnant?	☐ Yes	☐ No	☐ Unknown
Does the patient have an underlying chronic illness?	☐ Yes	☐ No	☐ Unknown
Is the patient immunosuppressed?	☐ Yes	☐ No	☐ Unknown
Is there a more likely clinical explanation for the patient's symptoms?	☐ Yes	☐ No	☐ Unknown

Clinical Syndrome: ☐ Febrile Illness ☐ Acute flaccid paralysis ☐ Meningitis ☐ Guillain-Barré Syndrome
☐ Encephalitis - including meningoencephalitis ☐ Other neuroinvasive

Patient Name: _____

Epidemiology

Did the patient donate or receive blood, blood products, or organ/tissue in the last 30 days?
☐ Yes ☐ No ☐ Unknown
***If yes**:*Type of product: ☐ Blood ☐ Blood products ☐ Organ/tissue
Donation date(s): _____/_____/_____; _____/_____/_____; _____/_____/_____
Transfusion/transplant date(s): _____/_____/_____; _____/_____/_____; _____/_____/_____
Blood Collection Agency/Medical Facility: _____

For infants only, was the patient breastfed? ☐ 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

In the 15 days prior to illness onset, did the patient travel or reside outside of their current residence county?
☐ Yes ☐ No ☐ Unknown ***If yes, provide dates and locations on page 3.***

Is case thought to be imported from another state or country? ☐ Yes ☐ No ☐ Unknown
If yes, from where: _____

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 ☐ Sexual ☐ In-Utero (transplacental) ☐ Perinatal ☐ Blood-borne
☐ Indeterminate ☐ Other (explain): _____

For Chikungunya Only:
Was the patient viremic while in Texas (during 7 days after onset)? ☐ Yes ☐ No ☐ Unknown
If yes, provide dates and locations where patient may have been bitten by mosquitoes on page 3.

Laboratory Findings

Test (IgM, IgG, PCR, or PRNT)	Date Collected	Lab	Source	Result	Interpretation
					☐ Positive ☐ Negative
					☐ Positive ☐ Negative
					☐ Positive ☐ Negative
					☐ Positive ☐ Negative
					☐ Positive ☐ Negative

Comments or Other Pertinent Epidemiological Data (*Use page 3 if necessary)*:

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

Patient Name: _____

Travel Dates and Locations Prior to Illness Onset				
Dates	**Area/Street Address**	**City**	**State**	**Country**

Other Persons Experiencing Similar Illness				
Name	**Telephone Number**	**Street Address**	**City**	**State**

For Chikungunya Only: Locations of Possible Mosquito Exposure While Viremic

Estimated dates of viremia: from ____/____/_____ to ____/____/_____

Date(s)	Street Address	City	County	Comments

Additional Comments or Other Pertinent Epidemiological Data: