TEXAS Health and Human Services | Texas Department of State Health Services

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

Arboviral Case Investigation

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

☐ Confirmed ☐ Probable ☐ Suspect

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 ____/____/_____

Was the patient hospitalized at a second hospital for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, name of hospital & dates: _____

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:			
Fever	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Anorexia	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown
Retro-orbital pain	☐ Yes	☐ No	☐ Unknown
Severe malaise	☐ Yes	☐ No	☐ Unknown
Nausea/Vomiting	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown
Stiff neck	☐ Yes	☐ No	☐ Unknown
Muscle weakness	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown
Joint/Bone pain	☐ Yes	☐ No	☐ Unknown
Rash	☐ Yes	☐ No	☐ Unknown
Vertigo	☐ Yes	☐ No	☐ Unknown

Neurological Evidence **(documented in medical record):**			
Altered taste	☐ Yes	☐ No	☐ Unknown
Abnormal reflexes	☐ Yes	☐ No	☐ Unknown
Nerve palsies	☐ Yes	☐ No	☐ Unknown
Ataxia	☐ Yes	☐ No	☐ Unknown
Altered mental state	☐ Yes	☐ No	☐ Unknown
Confusion	☐ Yes	☐ No	☐ Unknown
Seizures	☐ Yes	☐ No	☐ Unknown
Paralysis	☐ Yes	☐ No	☐ Unknown
CSF pleocytosis	☐ Yes	☐ No	☐ Unknown
Demyelinating neuropathy (including Guillain-Barré Syndrome)	☐ Yes	☐ No	☐ Unknown
Neuritis	☐ Yes	☐ No	☐ Unknown
Acute flaccid paralysis	☐ Yes	☐ No	☐ Unknown
Myelitis	☐ Yes	☐ No	☐ Unknown

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Clinical Evidence (continued)

Other neurological symptoms reported:

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Does the patient have an underlying chronic illness? *(Note in comments)* ☐ Yes ☐ No ☐ Unknown

Is the patient immunosuppressed? *(Note in comments)* ☐ Yes ☐ No ☐ Unknown

Is there a more likely clinical explanation for the patient's symptoms? *(Note in comments)* ☐ Yes ☐ No ☐ Unknown

Clinical Syndrome: ☐ Febrile Illness ☐ Acute flaccid paralysis ☐ Meningitis ☐ Guillain-Barré Syndrome
(check only one) ☐ Encephalitis - including meningoencephalitis ☐ Other neuroinvasive

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

NBS Patient ID: _____ Patient Name: _____

Comments or Other Pertinent Epidemiological Data (*Use page 4 if necessary)*:

Date First Reported: ____/____/_____ Investigation: Started ____/____/_____ Completed ____/____/_____

Reporting Facility:_____

Name of Investigator:_____ *(Please print clearly)*

Agency:_____ *(Please do not abbreviate)*

Phone:_____ E-Mail:_____

Travel Dates and Locations <u>Prior to Illness Onset</u>

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

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Additional Comments or Other Pertinent Epidemiological Data: