

# Dengue Case Investigation

- Dengue-like illness
- Dengue
- Severe Dengue

NBS Patient ID: \_\_\_\_\_

**PLEASE PRINT LEGIBLY**

## 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

### **Dengue-like illness (reported by patient or healthcare provider):**

Fever  Yes  No  Unknown

### **Dengue (fever PLUS one or more of the following):**

Headache  Yes  No  Unknown

Retro-orbital pain  Yes  No  Unknown

Nausea/Vomiting  Yes  No  Unknown

Abdominal pain  Yes  No  Unknown

Myalgia  Yes  No  Unknown

Joint/bone pain  Yes  No  Unknown

Rash  Yes  No  Unknown

Leukopenia (total white blood cell count <5,000/mm<sup>3</sup>)  Yes  No  Unknown

Extravascular fluid accumulation  Yes  No  Unknown

Positive tourniquet test  Yes  No  Unknown

Petechiae  Yes  No  Unknown

Purpura/Ecchymosis  Yes  No  Unknown

Mucosal bleeding  Yes  No  Unknown

Liver enlargement > 2 cm  Yes  No  Unknown

Increasing hematocrit with thrombocytopenia  Yes  No  Unknown

### **Severe Dengue (Dengue PLUS one or more of the following):**

Severe plasma leakage with respiratory distress  Yes  No  Unknown

Severe bleeding (i.e. melena, menorrhagia)  Yes  No  Unknown

Severe organ involvement  Yes  No  Unknown

Elevated liver transaminases (ALT or AST ≥ 1,000 U/L)  Yes  No  Unknown

Impaired consciousness  Yes  No  Unknown

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Patient Name: \_\_\_\_\_

**Epidemiology**

In the 30 days prior to onset, did the patient donate/receive:  Blood  Blood Product  Organ/Tissue  
If yes, date donated: \_\_\_\_\_ Blood Collection Agency: \_\_\_\_\_  
If yes, date blood, organ, or tissue received: \_\_\_\_\_ Medical Facility: \_\_\_\_\_

Does this patient have a recent vaccination against a flavivirus (e.g. Yellow fever or Japanese encephalitis)?  
 Yes  No  Unknown

Was the patient pregnant during illness?  Yes  No  Unknown  N/A

Was the patient breastfeeding within 2 weeks of onset?  Yes  No  Unknown  N/A

Occupation: \_\_\_\_\_  
*(give exact job, type of business or industry, work shift and % of time spent outside while at work)*

Average number of hours spent outdoors each day (in 30 days prior to onset):  <2  2-4  5-8  >8

When outdoors, what percentage of the time did the patient use mosquito repellent? 100% 75% 50% 25% 0%

Did the patient travel outside of their residence County within 15 days of illness onset?  
 Yes  No  Unknown

If yes, provide date of travel and locations: \_\_\_\_\_

Is case thought to be imported?  Yes  No  Unknown

If yes, from where : \_\_\_\_\_

Is this a dengue-endemic area?  Yes  No  Unknown

Is there evidence of ongoing transmission with other flaviviruses?  Yes  No  Unknown

Does the patient know anyone else experiencing a similar illness?  Yes  No  Unknown

If yes, provide names and contact information on page 3.

Case acquired: Vector Transplantation Transfusion Transplacental Breastfeeding Lab-Acquired Unknown

Was the patient viremic while in Texas (during 7 days after onset)?  Yes  No  Unknown

If yes, provide dates and locations where the patient may have been bitten by mosquitoes on page 3.

**Laboratory Findings**

Test	Date Collected	Lab	Source	Result	Interpretation
					<input type="checkbox"/> Positive <input type="checkbox"/> Negative
					<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism Identification	Date Collected	Lab	Source	Result	Interpretation
					<input type="checkbox"/> Positive <input type="checkbox"/> 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: \_\_\_\_\_

