Arboviral Infection

WEST VIRGINIA Department of Health & Human Resources BUREAU FOR PUBLIC HEALTH

(Do not use this form for dengue fever or yellow fever)

PATIENT DEMOGRAPHICS

*NAME (last, first): _____

*ADDRESS (mailing): _____

*ADDRESS (physical): _____

*City/State/Zip: _____

*PHONE (home): _____ **Phone** (work/cell) : _____

Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*

Name: _____ *Phone*: _____

*Birth date: __ / __ / ____ ***Age**: _____

*Sex: ☐Male ☐Female ☐Unk

*Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

*Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____

Investigation Start Date: __ / __ / ____

Earliest date reported to LHD: __ / __ / ____

Earliest date reported to DIDE: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk

Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other

Reporter Name: _____ Reporter Phone: _____

Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

*Onset date: __ / __ / ____   **Diagnosis date**: __ / __ / ____   **Recovery date**: __ / __ / ____

*Arbovirus Reported (if not below, list: _____)

☐Eastern Equine **(EEE)** ☐La Crosse **(LAC)** ☐Powassan **(POW)**
☐Western Equine **(WEE)** ☐St. Louis **(SLE)** ☐West Nile **(WNV)**
☐Zika Virus **(ZIK)** ☐Chikungunya **(CHK)**

*Clinical Findings

Y N U
☐ ☐ ☐ Fever (Highest measured temperature: _____ ^{o}F)
☐ ☐ ☐ Meningitis
☐ ☐ ☐ Encephalitis
☐ ☐ ☐ Myelitis
☐ ☐ ☐ Stupor
☐ ☐ ☐ Coma
☐ ☐ ☐ Paresis
☐ ☐ ☐ Acute flaccid paralysis
☐ ☐ ☐ Nerve palsies
☐ ☐ ☐ Abnormal reflexes
☐ ☐ ☐ Abnormal movements
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Arthralgia
☐ ☐ ☐ Conjunctivitis

Clinical Risk Factors

Y N U
☐ ☐ ☐ Underlying medical condition

☐ ☐ ☐ Immune suppression

Hospitalization

Y N U
☐ ☐ ☐ Patient hospitalized for this illness
If yes, hospital name: _____
Admit date: __ / __ / ____   Discharge date: __ / __ / ____

Death

Y N U
☐ ☐ ☐ Patient died due to this illness
If yes, date of death: __ / __ / ____

VACCINATION HISTORY

Y N U
☐ ☐ ☐ Ever vaccinated for yellow fever (If yes, date: __ / __ / ____)
☐ ☐ ☐ Ever vaccinated for Japanese encephalitis (If yes, date: __ / __ / ____)
☐ ☐ ☐ Ever vaccinated for tickborne encephalitis (If yes, date: __ / __ / ____)

LABORATORY *(Please submit copies of all labs, including CSF studies associated with this illness to DIDE)*

Y N U
☐ ☐ ☐ *Elevated white blood cell count (>5 WBCs adjusting for RBCs by subtracting 1 WBC for every 500 RBCs) in CSF specimen
☐ ☐ ☐ * Elevated protein in CSF specimen
☐ ☐ ☐ *Isolation of specific arbovirus or demonstration of specific arbovirus antigen or nucleic acid
☐ ☐ ☐ *Four-fold or greater change in arbovirus-specific quantitative antibody titer in paired sera
☐ ☐ ☐ *Arbovirus-specific IgM antibodies in serum **with** virus-specific neutralizing antibodies in same or later specimen (PRNT)
☐ ☐ ☐ *Arbovirus-specific IgM antibodies in CSF **with** negative result for other IgM antibodies in CSF to other arboviruses
☐ ☐ ☐ *Arbovirus-specific IgM antibodies in serum or CSF **with no further testing**

INFECTION TIMELINE

Exposure period

Onset date

⬇

Days from onset

_____ (Enter Max Incubation)*	_____ (Enter Min Incubation)*

Calendar dates:

__ / __ / ____	__ / __ / ____

⇦ __ / __ / ____

EPIDEMIOLOGIC EXPOSURES (based on the above exposure period, unless otherwise specified)

Y N U
☐ ☐ ☐ History of travel during exposure period (if yes, complete travel history below):

Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for travel

Y N U
☐ ☐ ☐ Artificial water-holding containers present near residence
☐ ☐ ☐ Areas of standing water present near residence
☐ ☐ ☐ Hardwood forest present near residence
☐ ☐ ☐ Poorly draining gutters present near residence
☐ ☐ ☐ Window/door screens in disrepair or missing at residence
　　　***Geographic coordinates of patient residence:**
　　　Latitude: _____　　Longitude: _____
　　　(Indicate units:
　　　☐Decimal Degrees ☐Degrees Minutes Seconds ☐Other)

Y N U
☐ ☐ ☐ Blood transfusion 30 days prior to onset (Date:__/__/____)
☐ ☐ ☐ Organ transplant 30 days prior to onset (Date:__/__/____)
☐ ☐ ☐ Case was prenatally exposed (in utero)
☐ ☐ ☐ Case is a breast-fed infant
☐ ☐ ☐ Outdoor recreational activities (e.g. hiking, camping, etc)
☐ ☐ ☐ Mosquito bite
☐ ☐ ☐ Tick bite (if Powassan or other tickborne arbovirus)
☐ ☐ ☐ Possible occupational exposure
　　　☐ Laboratory worker (Date of exposure:__/__/____)
　　　☐ Other occupation: _____

Where did exposure most likely occur?　　**County: _____　State:_____　Country: _____**

PUBLIC HEALTH ISSUES	PUBLIC HEALTH ACTIONS

Y N U
☐ ☐ ☐ Case identified through blood donor screening
☐ ☐ ☐ Case donated blood products, organs or tissue
　　in the 30 days prior to symptom onset
　　　Date:__/__/____
　　　Agency/location:_____
　　　Type of donation:_____
☐ ☐ ☐ Case is pregnant (Due date: __/__/____)
☐ ☐ ☐ Case knows someone who had shared exposure and is
　　currently having similar symptoms
☐ ☐ ☐ Epi link to another confirmed case of same condition
☐ ☐ ☐ Case is part of an outbreak
☐ ☐ ☐ Other:

Y N U
☐ ☐ ☐ Notify blood or tissue bank or other facility where organs donated
☐ ☐ ☐ Notify patient obstetrician
☐ ☐ ☐ Disease education and prevention information provided to patient
　　and/or family/guardian
☐ ☐ ☐ Recommended environmental measures to patient/family to reduce
　　risk around home
☐ ☐ ☐ Education or outreach provided to employer
☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a
　　shared exposure
☐ ☐ ☐ Patient is lost to follow-up
☐ ☐ ☐ Other:

WVEDSS

Y N U
☐ ☐ ☐ Entered into WVEDSS (**Entry date**: __ / __ / ____)　　**Case Status:** ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

NOTES

*Incubation Periods:
EEE= 4-10 days **LAC**= 5-15 days **POW**= 7-28 days **WEE**= 5-15 days **WNV**= 2-14 days **SLE**= 5-15 days **CHIK**= 3-7 days **ZIK**= 2-7 days