

Arbovirus Case Report Form



When completed, fax or mail this form to:
 Epidemiology and Response Division, NMDOH
 1190 St. Francis Drive, N-1350
 Santa Fe, NM 87505
 Phone: (505) 827-0006 Fax: (505) 827-0013

Case Status (Office of EPI Use Only):
 Confirmed
 Probable
 Suspect
 Asymptomatic Blood Donor

Date Received _____ Date Interviewed _____ NM-EDSS Number _____

Arbovirus & Clinical Syndrome

WNV CHKV DENV YFV Other: _____

Asymptomatic Uncomplicated Fever Meningitis Encephalitis/Meningoencephalitis Hepatitis/Jaundice Unk
 Dengue Dengue-Like Illness Severe Dengue Multi-System Organ Failure Other Neuroinvasive Other Clinical

Patient Demographics

Patient Name (last, first) _____

DOB _____ Sex Male Female Patient's Age _____ Years _____ Months

Phone Number (Home) _____ Phone Number (Work) _____ Phone Number (Cell) _____

Address (Street) _____ Race
 Am Indian/Alaskan native
 Asian/Pacific Islander
 White Black Unknown
 Ethnicity
 Hispanic
 Non-Hispanic

City _____ County _____ State _____ ZIP _____

Parent/Spouse/Guardian Name (Last, First) _____

Physician/Provider Name (Last, First) _____ Phone Number (Physician/Provider) _____

Laboratory Results

Blood or Serum

Cerebral Spinal Fluid

Blood or Serum		Cerebral Spinal Fluid	
Name of Laboratory		Name of Laboratory	
Date	CBC results	Date	CSF results
WBC Count	Leucopenia <input type="checkbox"/> yes <input type="checkbox"/> no	WBC Count	Leucopenia <input type="checkbox"/> yes <input type="checkbox"/> no
ELISA IgM	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> equivocal	ELISA IgM	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> equivocal
ELISA IgG	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> equivocal	ELISA IgG	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> equivocal
PCR or NAT	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> equivocal	PCR or NAT	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> equivocal
Hematocrit	Increasing <input type="checkbox"/> yes <input type="checkbox"/> no	PRNT	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> equivocal
Platelets	Decreasing <input type="checkbox"/> yes <input type="checkbox"/> no		

Symptoms & Outcome

Symptomatic <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Onset Date _____	Headache <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Acute Flaccid Paralysis <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Fever <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk Temperature: _____	Chills/Rigors <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Fatigue/Malaise <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Rash <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Conjunctivitis <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Nausea/Vomiting <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Myalgia <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Arthralgia <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Arthritis <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Paresis/Paralysis <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Stiff Neck <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Ataxia <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Parkinsonism/ Cogwheel Rigidity <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Altered Mental Status <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Seizures <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Retro-Orbital Pain <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Tourniquet Test Positive <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Abdominal Pain/Tenderness <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Persistent Vomiting <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Extravascular Fluid Accumulation <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Mucosal Bleeding <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Liver Enlargement <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk
Severe Plasma Leakage <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Severe Bleeding <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Severe Organ Involvement <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk

Other Symptoms _____ Serotype (Dengue Only) DEN-1
 DEN-2 DEN-3 DEN-4

Patient's Name		DOB
Hospitalized <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Name of Hospital	
Date of Admit	Date of Discharge	<input type="checkbox"/> Survived <input type="checkbox"/> Died
Date of Death	Autopsy Performed <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Date of Autopsy
Risk Factors for Infection		
<p>Does the patient report mosquito bites in the two weeks before illness onset? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk</p> <p>If yes, where and when</p>		
<p>Did the patient travel outside his/her home county, state or country in the two weeks before illness onset? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk</p> <p>If yes, destination(s) and dates spent (at each)</p>		
<p>Did the patient receive any blood products or organs in the month before illness began? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk</p> <p>Date received Product type</p>		
<p>Did the patient donate any blood products or organs in the month before illness began? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk</p> <p>Date donated Product type</p>		
Is the patient pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Due date or date of delivery	
Is the patient a breast fed infant? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	Infected in utero <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk	
Interviewer Information		
Interviewer Name	Interviewer Phone	
Comments		