Arbovirus Case Report Form

NEW MEXICO DEPARTMENT OF HEALTH

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	
Name of Laboratory		Name of Laboratory	
Date	**CBC results**	Date	**CSF results**
WBC Count	Leucopenia ☐ yes ☐ no	WBC Count	Leucopenia ☐ yes ☐ no
ELISA IgM	☐ positive ☐ negative ☐ equivocal	ELISA IgM	☐ positive ☐ negative ☐ equivocal
ELISA IgG	☐ positive ☐ negative ☐ equivocal	ELISA IgG	☐ positive ☐ negative ☐ equivocal
PCR or NAT	☐ positive ☐ negative ☐ equivocal	PCR or NAT	☐ positive ☐ negative ☐ equivocal
Hematocrit	Increasing ☐ yes ☐ no	PRNT	☐ positive ☐ negative ☐ equivocal
Platelets	Decreasing ☐ yes ☐ no		

Symptoms & Outcome

Symptomatic ☐ yes ☐ no ☐ unk	Onset Date	Headache ☐ yes ☐ no ☐ unk
Acute Flaccid Paralysis ☐ yes ☐ no ☐ unk	Fever ☐ yes ☐ no ☐ unk Temperature:	Chills/Rigors ☐ yes ☐ no ☐ unk
Fatigue/Malaise ☐ yes ☐ no ☐ unk	Rash ☐ yes ☐ no ☐ unk	Conjunctivitis ☐ yes ☐ no ☐ unk
Nausea/Vomiting ☐ yes ☐ no ☐ unk	Diarrhea ☐ yes ☐ no ☐ unk	Myalgia ☐ yes ☐ no ☐ unk
Arthralgia ☐ yes ☐ no ☐ unk	Arthritis ☐ yes ☐ no ☐ unk	Paresis/Paralysis ☐ yes ☐ no ☐ unk
Stiff Neck ☐ yes ☐ no ☐ unk	Ataxia ☐ yes ☐ no ☐ unk	Parkinsonism/ Cogwheel Rigidity ☐ yes ☐ no ☐ unk
Altered Mental Status ☐ yes ☐ no ☐ unk	Seizures ☐ yes ☐ no ☐ unk	Retro-Orbital Pain ☐ yes ☐ no ☐ unk
Tourniquet Test Positive ☐ yes ☐ no ☐ unk	Abdominal Pain/ Tenderness ☐ yes ☐ no ☐ unk	Persistent Vomiting ☐ yes ☐ no ☐ unk
Extravascular Fluid Accumulation ☐ yes ☐ no ☐ unk	Mucosal Bleeding ☐ yes ☐ no ☐ unk	Liver Enlargement ☐ yes ☐ no ☐ unk
Severe Plasma Leakage ☐ yes ☐ no ☐ unk	Severe Bleeding ☐ yes ☐ no ☐ unk	Severe Organ Involvement ☐ yes ☐ no ☐ unk
Other Symptoms		Serotype (Dengue Only) ☐DEN-1 ☐ DEN-2 ☐DEN-3 ☐DEN-4

Patient's Name		DOB
Hospitalized ☐ yes ☐ no ☐ unk	Name of Hospital	
Date of Admit	Date of Discharge	☐ Survived ☐ Died
Date of Death	Autopsy Performed ☐ yes ☐ no ☐ unk	Date of Autopsy

Risk Factors for Infection

Does the patient report mosquito bites in the two weeks before illness onset? ☐ yes ☐ no ☐ unk
If yes, where and when

Did the patient travel outside his/her home county, state or country in the two weeks before illness onset? ☐ yes ☐ no ☐ unk
If yes, destination(s) and dates spent (at each)

Did the patient receive any blood products or organs in the month before illness began? ☐ yes ☐ no ☐ unk
Date received Product type

Did the patient donate any blood products or organs in the month before illness began? ☐ yes ☐ no ☐ unk
Date donated Product type

Is the patient pregnant? ☐ yes ☐ no ☐ unk	Due date or date of delivery
Is the patient a breast fed infant? ☐ yes ☐ no ☐ unk	Infected in utero ☐ yes ☐ no ☐ unk

Interviewer Information

Interviewer Name	Interviewer Phone

Comments