



Arboviral Disease

County _____

Case name (last, first) _____
 Birth date ___/___/___ Age at symptom onset _____ Years Months
 Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American
 Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:

Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
 Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
 Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
 Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
 Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
 Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
 Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
 South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
 Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
 Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
 Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
 Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
 Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
 Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____
 Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk **Symptom Onset** ___/___/___ Derived Diagnosis date ___/___/___
Arboviral agent suspected _____

Clinical Features

Primary clinical syndrome Asymptomatic Uncomplicated fever Meningitis Encephalitis/meningoencephalitis
 Other neuroinvasive Hepatitis/jaundice Multi-organ failure
 Kidney (renal) abnormality or failure Congenital infection Unk
 Other clinical syndrome _____

Y N Unk

Asymptomatic (no clinical illness)

Any fever, subjective or measured If yes, Temp measured? Yes No Highest measured temp _____ °F

If no, **Y N Unk**

Used OTC medications that reduced fever

Other potential reason for lack of fever _____

Y N Unk

Chills or rigors

Rash

Headache

Fatigue

Malaise

Conjunctivitis

Nausea

Vomiting

Diarrhea (3 or more loose stools within a 24 hour period)

Myalgia (muscle aches or pain)

Arthralgia (joint pain)

Arthritis

Abdominal pain or tenderness

Retro-orbital pain

Nuchal rigidity (stiff neck)

Photophobia (eyes sensitive to light)

Y N Unk

Neuroinvasive illness

Paresis

Abnormal reflexes

Acute flaccid paralysis

Altered mental status

Ataxia

Limb weakness (documented by HCP)

Nerve palsies

Peripheral neuritis

Peripheral demyelinating neuropathy

Parkinsonism or cogwheel rigidity

Sensory deficit

Y N Unk

- Seizure new with disease**
 Encephalitis / meningoencephalitis
 Myelitis
 Guillain-Barre syndrome
 Other neuroinvasive _____

Y N Unk

- Hemorrhagic signs**
 Blood in vomitus, stool, urine
 Epistaxis (nose bleed)
 Gum bleeding
 Petechiae
 Positive tourniquet test
 Positive urinalysis
 Purpura/ecchymosis
 Vaginal Bleeding
 Other _____
 Plasma leakage or pleural effusion or ascites
 Jaundice or hepatitis
 Myocarditis
 Shock syndrome (hypotension, clammy skin, rapid pulse)
 Any complication _____
 More likely diagnosis or clinical explanation _____
 Previous flavivirus infection (e.g., dengue, SLE) _____

*Dengue Only***Y N Unk**

- Extravascular fluid accumulation** (e.g., pleural or pericardial effusion, ascites)
 With respiratory distress
 Hypovolemic shock with respiratory distress
 Hepatomegaly (liver enlargement >2 centimeters)
 Persistent vomiting
 Severe bleeding from gastrointestinal tract or vagina
 Severe organ involvement
 Multiple organ failure
 Kidney (renal) abnormality or failure

*Infant Only***Y N Unk**

- Congenital abnormalities**
 Microcephaly at birth
 Intracranial calcifications
 Clubfoot or multiple joint contractures
 Structural brain or eye abnormalities
 Other congenital CNS abnormalities _____

Predisposing Conditions**Y N Unk**

- Alcoholism
 Asthma/reactive airway disease
 Bone marrow transplant
 Chronic heart disease
 Chronic kidney disease
 Chronic liver disease
 Chronic obstructive lung disease
 Diabetes mellitus
 Heart attack
 High blood pressure
 Hyperlipidemia
 Immunosuppressive therapy or condition, or disease _____
 Obesity
 Organ transplant
 Sickle cell disease
 Stroke
 Thyroid disease

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
 Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Y N Unk

Mechanical ventilation or intubation required
 Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ Please fill in the death date information on the Person Screen
 Autopsy performed
 Death certificate lists disease as a cause of death or a significant contributing condition

Pregnancy

Pregnancy status at time of symptom onset

Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
 OB name, phone, address _____
Outcome of pregnancy Still pregnant Fetal death (miscarriage or stillbirth) Abortion
 Other _____
 Delivered – full term Delivered – premie Delivered – Unk
 Delivery method Vaginal C-section Unk
 Postpartum (Estimated) delivery date ___/___/___
 OB name, phone, address _____
Outcome of pregnancy Fetal death (miscarriage or stillbirth) Abortion
 Other _____
 Delivered – full term Delivered – premie Delivered – Unk
 Delivery method Vaginal C-section Unk
 Neither pregnant nor postpartum Unk

Vaccination

Y N Unk

Japanese encephalitis or yellow fever vaccine in past
 Vaccine information available Yes No
 Date of vaccine administration ___/___/___ Vaccine administered (Type) _____
 Vaccine lot number _____ Administering provider _____

Clinical testing

Y N Unk

CSF obtained
 Abnormal CSF profile
 Glucose _____ Percent lymphocytes _____ Percent neutrophils _____
 Protein _____ Red blood cells _____ While blood cells _____

Y N Unk

Pleocytosis (CSF)
 Thrombocytopenia *Thrombocytopenia defined as platelets < 100,000 /mm³*

Dengue Only

Y N Unk

Leukopenia *Leukopenia defined as total white blood cell count < 5,000/mm³*
 Increasing hematocrit concurrent with rapid decrease in platelet count
 Elevated liver transaminases (AST or ALT ≥ 1,000 per liter)

RISK AND RESPONSE (Ask about exposures 2-15 days before symptom onset. For Powassan virus, use 4-30 days.)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Dengue Only

Y N Unk

During the previous two weeks prior to onset of fever, travel to a dengue endemic country or presence in a location experiencing an ongoing dengue outbreak

Risk and Exposure Information

Y N Unk

- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
- Does the case know anyone else with similar symptoms or illness Ill contact's onset date ___/___/___
 Contact setting/relationship to case Common Event Common meal Day care Female sexual partner
 Male sexual partner Friend Household contact Workplace
 Travel contact Other _____
- Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
 Activity Outdoor recreation Cabin Hunting Lawn mowing Other _____
 Where At home property Elsewhere _____
- Insect bite Date of exposure ___/___/___
 Type Tick Mosquito Flea Louse Deer fly Other _____
 Location of exposure Multiple exposures Other country Other state Unk WA county _____
 Specify location _____
- Blood transfusion or blood products (e.g., IG, factor concentrates) recipient** Date ___/___/___
- Organ or tissue transplant recipient** Date ___/___/___
- (Potential) Occupational exposure
 Lab worker
 Other Occupation _____

Dengue Only

- During the previous two weeks prior to onset of fever, association in time and place with a confirmed or probable dengue case**

Infant Only

- Birth mother had symptom(s) consistent with Zika virus disease (e.g. fever, rash, arthralgia, or conjunctivitis)**
- Birth mother had lab evidence of Zika or unspecified flavivirus during pregnancy**
- Birth mother lived in or had traveled to endemic area**
- Breast fed**
- Infected in utero**

- No risk factors or likely exposures could be identified

Exposure and Transmission Summary

Y N Unk

- Epi-linked to a confirmed case**
- Sexual contact with person with laboratory confirmed or probable Zika infection**

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Vectorborne Sexual Blood products Unk Other _____
Describe _____

Exposure summary

Public Health Issues

Y N Unk

- Did case donate blood products in the 30 days before symptom onset** Date ___/___/___
 Agency/location _____ Type of donation _____
- Did case donate organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis**
 Date ___/___/___
 Agency/location _____ Type of donation _____

Public Health Interventions/Actions

Y N Unk

- Breastfeeding education provided
- Sexual transmission prevention education provided
- Notified blood or tissue bank (if recent donation)
- Letter sent Date ___/___/___ Batch date ___/___/___
- Any other public health action _____

NOTES**LAB RESULTS**Lab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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