Washington State Department of Health

# Arboviral Disease

**County**

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other 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
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

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

**Investigation start date** ___/___/___

Investigation complete date ___/___/___

**Case complete date** ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

## DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

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

**Race** (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

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 _____

## REPORT SOURCE

**Initial report source** _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

## 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 _____
Contact name _____
Contact phone _____

## 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 _____ºF

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
☐ ☐ ☐ **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 ___/___/___
☐ ☐ ☐ 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 – preemie ☐ 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 – preemie ☐ 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 /mm^3*

*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: | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ Other _____ | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ Other _____ | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ 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 ☐ Pending
Test 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 document**

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____