Washington State Department of Health

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 childs) 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

Case Name _____ LHJ Case ID _____

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 _____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

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 – 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 _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ 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 _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.