ARBOVIRAL INVESTIGATION FORM

Non-Neuroinvasive	Neuroinvasive	
☐ West Nile Fever	☐ Encephalitis, West Nile ☐ Encephalitis, St. Louis ☐ Encephalitis, Cache Valley ☐ Encephalitis, LaCrosse (California serogroup)	☐ Eastern Equine Encephalitis ☐ Venezuelan Equine Encephalitis ☐ Western Equine Encephalitis

Dates

__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
Onset	Physician Date	ER Visit	Hsp Admit	Rep to Area/County

Basic Demographic Data

Last Name: ________________________________ First Name:____
Middle Name:______________________________ Suffix: ____________________________
DOB: __ __ / __ __ /__ __ __ __ Age: _______ mon / years Current Sex: Female Male Unknown
Is the patient deceased? No Unknown Yes Deceased Date: __ __ / __ __ /__ __ __ __

Street Address 1: ____
Street Address 2: ____
City: ____ State:___________
Zip Code: __ __ __ __ __- __ __ __ __ County:________________________________ Country:______________

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Cell Phone: (__ __ __) -- __ __ __ - __ __ __ __
Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __ Message: (__ __ __) -- __ __ __ - __ __ __ __

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race : Unknown American Indian or Alaska Native Asian
Black or African American Native Hawaiian or Other Pacific Islander White

Investigation Summary

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: Open Closed
Investigator:____ Date assigned: __ __ / __ __ /__ __ __

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __
Reporting Source:____
Earliest Date Reported to: County: __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __
Reporter:____

Clinical

Attending Physician's Name:____
Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Was patient hospitalized for this illness? No Unknown Yes
If yes: Hospital Name:____
Admission Date : __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __
Duration of Stay _______________ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __
Illness End Date: __ __ / __ __ /__ __ __ __ Illness Duration: ____ Circle:days/hrs./minutes/months/unknown/weeks/years
Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
Did the patient die from this illness? No Unknown Yes

Epidemiologic

Is this patient associated with a day care facility? No Unknown Yes	Is this patient a food handler? No Unknown Yes
Is this case part of an outbreak? No Unknown Yes	If yes, outbreak name:

Where was the disease acquired?

Indigenous within jurisdiction	Out of Country	Out of jurisdiction, from another jurisdiction
Out of state	Unknown	

If the answer is out of Country, Jurisdiction, or State, where was it acquired?

Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

Airborne	Bloodborne	Dermal	Foodborne	Indeterminate	Mechanical
Nosocomial	Sexually Transmitted	Vectorborne	Waterborne	Zoonotic	Other

Confirmation Method

Active Surveillance	Case Outbreak Investigation	Clinical Diagnosis	Epidemiologically Linked
Laboratory Confirmed	Laboratory Report	Local/State Specified	Medical Record Review
No information given	Occupational Disease Surveillance	Provider Certified	Other

Confirmation Date: __ __ / __ __ / __ __ __ __
CASE STATUS (Required for Notification) **Confirmed** **Not a Case** **Probable** **Suspect** **Unknown**
MMWR Week: _____ **MMWR Year:** __________

Administrative

General Comments:____
____

Custom Fields

Date Due: __ __ / __ __ / __ __ __ __ Investigation ready for Supervisor review:______________________________
Date investigation ready for supervisor review: __ __ / __ __ / __ __ __ __

Condition Specific Custom Fields

Does the physician feel the patient had WNV/SLE/La Crosse/CVV/EEE/VEE/WEE? No Unknown Yes

Is the patient an organ donor? No Unknown Yes | Has the patient had an organ transplant? No Unknown Yes

Is the patient a blood donor? No Unknown Yes | Has patient received a blood transfusion? No Unknown Yes

Symptoms

Fever No Unknown Yes Highest Temp: _______°F | Altered Mental Status No Unknown Yes

Headache No Unknown Yes | Confusion No Unknown Yes

Stiff Neck No Unknown Yes | Seizure No Unknown Yes

Other Neurologic Signs No Unknown Yes If yes, describe: ____

Muscle Weakness/Pain No Unknown Yes If yes, distribution & character: ________________________________

Rash No Unknown Yes If yes, distribution & character: ________________________________

Exposure

What is the patient's occupation? __________________ | What percent of time at work is spent outdoors? _______%

During the 2 weeks prior to onset, did patient get bit by a mosquito? Yes No

During the 2 weeks prior to onset, what is the average number or hours spent outdoors each day? _________hrs

How often is mosquito repellent used during time spent outdoors?
Never < 25% of time 25 – 50 % of time 50 – 75% of time > 75% of time, but not always Always

If mosquito repellent was used, did it contain DEET? No Unknown Yes

Laboratory Information

CSF
WBC: ________ | Differential: __________(%) Segs __________(%) Lymphs | Glucose __________ | Protein __________

Resulted Test

West Nile Virus
St. Louis encephalitis
Cache Valley Virus
California serogroup/ LaCrosse
Easter Equine Encephalitis
Venezuelan Equine Encephalitis
Western Equine Encephalitis

Specimen	CSF	Acute Serum	Convalescent Serum	Other:_____________
Date Collected	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
IgM ELISA Result (numeric)				
IgG ELISA Result (numeric)				
PCR Result				
Other Test				
Testing Lab (name and city)				

Vaccine/Travel History

Has the patient ever had:

Yellow Fever Vaccine? No Unknown Yes | Central European Encephalitis Vaccine? No Unknown Yes

Japanese Encephalitis Vaccine? No Unknown Yes | Dengue Fever? No Unknown Yes

Military Service? No Unknown Yes | Flavivirus Infection (e.g., St. Louis Enceph) No Unknown Yes

In the 2 weeks prior to onset, did the patient:
Travel outside the United States? No Unknown Yes If yes, where? _______________ Dates: ________________
Travel outside Alabama? No Unknown Yes If yes, where? _______________ Dates: ________________