YELLOW FEVER INVESTIGATION FORM

Comments _____

_____

_____

Basic Demographic Data

Last Name: _____ First Name:_____

Middle Name:_____ Suffix: _____

DOB: __ __ / __ __ /__ __ __ __ Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐Unknown ☐Yes Deceased Date: __ __ / __ __ /__ __ __ __

Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown

SSN: __ __ __ / __ __ /__ __ __ __

Identification Information: Type:_____Assigning Authority_____IDValue_____

Street Address 1: _____

Street Address 2: _____

City: _____ State:_____

Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

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

Physician's Name: _____

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

Physician's Address: _____

City:_____ State:_____

Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Hospital

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes

If yes: Hospital Name: _____

Admission Date__ __ / __ __ /__ __ __ __ Discharge Date __ __ / __ __ /__ __ __ __

Total Duration of stay within hospital _____days

Condition

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

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

Transmission Mode

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

Detection Method

☐ Patient Self-referral	☐ Prenatal Testing	☐ Prison Entry Screening	☐ Provider Reported	☐ Routine Physical	☐ Other

Confimation 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

(Required for notification) MMWR Week _____ **MMWR Year** _____

Custom Fields

Date Due __ __ / __ __ /__ __ __ __ Investigation Ready for Supervisor Review:_____

Date Investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Condition Specific Custom Fields	
Clinical criteria for case classification	
A. An acute onset:	☐ No ☐ Unknown ☐ Yes
B. Constitutional symptoms	☐ No ☐ Unknown ☐ Yes
Recurrance	
A. Fever:	☐ No ☐ Unknown ☐ Yes
B. Hepatitis:	☐ No ☐ Unknown ☐ Yes
C. Albuminuria:	☐ No ☐ Unknown ☐ Yes
Laboratory criteria for case classification	
Fourfold or greater rise in yellow fever antibody titer:	☐ no ☐ not tested ☐ unknown ☐ yes
Demonstration of yellow fever virus, antigen, or genome:	☐ no ☐ not tested ☐ unknown ☐ yes
History of yellow fever vaccination:	☐ no ☐ not tested ☐ unknown ☐ yes

Vaccination Record (Use Manage Vaccinations button)

Date Administered:	__ __ / __ __ /__ __ __ __
Age at Vaccination:	**(Circle):** /days /hrs ./ minutes / months / unknown / weeks/ years

Vaccination Anatomical Site: ☐ Left Arm ☐ Left Gluteus Maximus ☐ Left Naris ☐ Left Thigh ☐ Oral Cavity ☐ Right Arm ☐ Right Gluteus Maximus ☐ Right Naris ☐ Right Thigh ☐ Other

Given By	
Provider:	Organization:
Vaccine Administered:	Vaccine Manufacturer:
Lot Number:	Expiration Date: __ __ / __ __ /__ __ __ __