

Today's date: \_\_\_/\_\_\_/\_\_\_  
Day Month Year



# DENGUE CASE INVESTIGATION REPORT

CDC Dengue Branch and Puerto Rico Department of Health  
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Form Approved OMB No.

## FOR CDC DENGUE BRANCH USE ONLY

Case number	Specimen #	Days post onset (DPO)	Type	Date Received	Specimen #	Days post onset (DPO)	Type	Date Received
SAN ID	GCODE	S1			S3			
		S2			S4			

Please read and complete ALL sections

<b>Patient Data</b>	Hospitalized due to this illness: <input type="checkbox"/> No <input type="checkbox"/> Yes	→ Hospital Name:	Record Number:
Name of Patient: Last Name _____ First Name _____ Middle Name or Initial _____			Fatal: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>
If patient is a minor, name of father or primary caregiver: Last Name _____ First Name _____ Middle Name or Initial _____			Mental Status Changes: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>

**Home (Physical) Address**

Home address here →

City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Tel: \_\_\_\_\_ Other Tel: \_\_\_\_\_

Residence is close to:

**Physician who referred this case**

Name of Healthcare Provider: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Send laboratory results to (mailing address):

**Patient's Demographic Information**

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ month Sex:  M  F  
or Age: \_\_\_ years Pregnant:  Y  N

UNK Day Month Year

**Who filled out this form?**

Name (complete) \_\_\_\_\_

Relationship with patient: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Must have the following information for sample processing**

Date of first symptom: \_\_\_/\_\_\_/\_\_\_

Date specimen taken: \_\_\_/\_\_\_/\_\_\_

Serum: First sample (Acute = first 5 days of illness - check for virus) \_\_\_/\_\_\_/\_\_\_

Second sample (Convalescent = more than 5 days after onset - check for antibodies) \_\_\_/\_\_\_/\_\_\_

Third sample \_\_\_/\_\_\_/\_\_\_

Fatal cases (tissue type): \_\_\_/\_\_\_/\_\_\_

**Additional Patient Data**

- How long have you lived in this city? \_\_\_\_\_
- Country of birth \_\_\_\_\_
- Have you been diagnosed with dengue before?  Yes  No  Unk
- When diagnosed? \_\_\_/\_\_\_/\_\_\_  Yes  No  Unk
- Got Yellow Fever Vaccine vaccinated  Yes  No  Unk Year \_\_\_\_\_
- During the 14 days before onset of illness, did you TRAVEL to other cities or countries?  Yes, another country  Yes, another city  No  Unk

## PLEASE describe below the signs and symptoms that the patient has at the time that this form is being completed

<b>Unk</b>	<b>Yes</b>	<b>No</b>	<b>Evidence of capillary leak</b>	<b>7. WHERE did you TRAVEL?</b>	<b>Warning Signs</b>	<b>Yes</b>	<b>No</b>
	<input type="checkbox"/>	<input type="checkbox"/>	Lowest hematocrit (%) _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Fever Lasting 2-7 days.....	<input type="checkbox"/>	<input type="checkbox"/>	Highest hematocrit (%) _____		Persistent Vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>
Fever Now (>38°C).....	<input type="checkbox"/>	<input type="checkbox"/>	Lowest serum albumin _____		Abdominal pain/Tenderness..	<input type="checkbox"/>	<input type="checkbox"/>
Platelets ≤100,000/mm <sup>3</sup> .....	<input type="checkbox"/>	<input type="checkbox"/>	Lowest serum protein _____		Mucosal Bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
Platelet count: _____			Lowest blood pressure (SBP/DBP) _____/____		Lethargy, restlessness.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Any hemorrhagic manifestation</b>			Lowest pulse pressure (systolic - diastolic) _____		Liver Enlargement >2cm.....	<input type="checkbox"/>	<input type="checkbox"/>
Petechiae.....	<input type="checkbox"/>	<input type="checkbox"/>	Lowest white blood cell count (WBC) _____		Pleural or abdominal effusion..	<input type="checkbox"/>	<input type="checkbox"/>
Purpura/Echymosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Symptoms</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>Additional symptoms</b>
Vomit with blood.....	<input type="checkbox"/>	<input type="checkbox"/>	Rapid, weak pulse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea.....
Blood in stool.....	<input type="checkbox"/>	<input type="checkbox"/>	Pallor or cool skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough.....
Nasal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Chills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conjunctivitis.....
Bleeding gums.....	<input type="checkbox"/>	<input type="checkbox"/>	Rash.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Congestion.....
Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat.....
Vaginal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....
Positive urinalysis.....	<input type="checkbox"/>	<input type="checkbox"/>	Body (muscle/bone) pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion or coma.....
(over 5 RBC/hpf or positive for blood)	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea and Vomiting.....
			Anorexia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Swollen Joints).....

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**Specimen No.**

S<sup>1</sup> \_\_\_\_\_

S<sup>2</sup> \_\_\_\_\_

S<sup>3</sup> \_\_\_\_\_

**SEROLOGY  
LUMINEX (MIA)**

S <sup>1</sup>			S <sup>2</sup>			S <sup>3</sup>		
Test Date	Ag	Titer	Test Date	Ag	Titer	Test Date	Ag	Titer

**IgG ELISA**

S <sup>1</sup>				S <sup>2</sup>				S <sup>3</sup>			
Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer

**IgM ELISA**

S <sup>1</sup>			S <sup>2</sup>			S <sup>3</sup>		
Test Date	Ag	P/N	Test Date	Ag	P/N	Test Date	Ag	P/N

**Neutralization**

S <sup>1</sup>			S <sup>2</sup>			S <sup>3</sup>		
Test Date	Screen	Titer	Test Date	Screen	Titer	Test Date	Screen	Titer
DENV-1								
DENV-2								
DENV-3								
DENV-4								
WEST NILE								
SLE								
YFV								

**Viral Isolation & PCR**

S <sup>1</sup>				S <sup>2</sup>				S <sup>3</sup>			
Test Date	ID	Isotech	IDtech	Test Date	ID	Isotech	IDtech	Test Date	ID	Isotech	IDtech

Serology Lab Director Signature: \_\_\_\_\_

Virology Lab Director Signature: \_\_\_\_\_ Overall dengue interpretation: \_\_\_\_\_

This questionnaire is authorized by law (Public Health Service Act 42 USC 241). Although response to the questions asked is voluntary, cooperation of the patient is necessary for the study and control of the disease. Public reporting burden for the collection of information is estimated to average 15 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to PHS Reports Clearance Officer; Rm. 721-H, Humphrey Bg; 200 Independence Ave., SW; Washington, DC 20201; ATTN: PRA, and to the Office of information and Regulatory Affairs, Office of Management and Budget, Washington, DC.