

Today's date: ___/___/___
Day Month Year



DENGUE CASE INVESTIGATION REPORT

CDC Dengue Branch and Puerto Rico Department of Health
1324 Calle Cañada, San Juan, P. R. 00920-3860
Tel. (787) 706-2399, Fax (787) 706-2496



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

Patient Data	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 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

<p>Unk Yes No</p> <p>Fever Lasting 2-7 days..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fever Now (>38°C)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Platelets ≤100,000/mm³..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Platelet count: _____</p> <p>Any hemorrhagic manifestation</p> <p>Petechiae..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Purpura/Echymosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Vomit with blood..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood in stool..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nasal bleeding..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bleeding gums..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood in urine..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Vaginal bleeding..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Positive urinalysis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(over 5 RBC/hpf or positive for blood) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Evidence of capillary leak</p> <p>Lowest hematocrit (%) _____</p> <p>Highest hematocrit (%) _____</p> <p>Lowest serum albumin _____</p> <p>Lowest serum protein _____</p> <p>Lowest blood pressure (SBP/DBP) _____/_____ Lowest pulse pressure (systolic - diastolic) _____</p> <p>Lowest white blood cell count (WBC) _____</p> <p>Symptoms</p> <p>Rapid, weak pulse..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pallor or cool skin..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chills..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rash..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Headache..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eye pain..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Body (muscle/bone) pain..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint pain..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anorexia..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Warning Signs Yes No</p> <p>7. WHERE did you TRAVEL? _____ Unk <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent Vomiting..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Abdominal pain/Tenderness.. <input type="checkbox"/> <input type="checkbox"/></p> <p>Mucosal Bleeding <input type="checkbox"/> <input type="checkbox"/></p> <p>Lethargy, restlessness..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Liver Enlargement >2cm..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Pleural or abdominal effusion.. <input type="checkbox"/> <input type="checkbox"/></p> <p>Additional symptoms</p> <p>Diarrhea..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Cough..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Conjunctivitis..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Nasal Congestion..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Sore throat..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Jaundice..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Convulsion or coma..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Nausea and Vomiting..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis (Swollen Joints)..... <input type="checkbox"/> <input type="checkbox"/></p>
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Specimen No.

S¹ _____ S² _____ S³ _____

**SEROLOGY
LUMINEX (MIA)**

S ¹			S ²			S ³		
Test Date	Ag	Titer	Test Date	Ag	Titer	Test Date	Ag	Titer

IgG ELISA

S ¹				S ²				S ³			
Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer

IgM ELISA

S ¹			S ²			S ³		
Test Date	Ag	P/N	Test Date	Ag	P/N	Test Date	Ag	P/N

Neutralization

S ¹			S ²			S ³		
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 ¹				S ²				S ³			
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.