



DENGUE CASE INVESTIGATION REPORT

CDC Dengue Branch and Puerto Rico Department of Health

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For CDC Dengue Branch use only

GCODE	Specimen #	Days post onset (DPO)	Type	Received (Date)	Specimen #	Days post onset (DPO)	Type	Received (Date)
	S1			/ /	S3			/ /
	S2			/ /	S4			/ /

Please complete all sections

Hospitalized: No Yes Fatal: Yes No Encephalitis: Yes No

Hospital: _____

Name: _____

Last Name _____ First Name _____ Middle Name / Initial _____

If a minor, name of parent or person in charge: _____

Home Address	Physician who referred the case:
City, Town: _____	Name: _____
Urbanization or sector: _____	Phone number: _____
Street: _____ Number: _____	Send results to: _____
Premise No.: _____ Box: _____ P.O.Box: _____	
Road No.: _____ Km: _____ Hm: _____ Tel.: _____	
Close to: _____	

Work Address: _____

Additional Data

1) Country of birth: _____

Patient's Basic Information

Date of birth: _____ Age: _____ years Sex: Male Female

2) Have you had dengue before (fever, body pain, eye pain, rash) Yes No Don't know

3) When? (Month, Year) _____ / _____ No Don't know

Indispensable information for sample processing

Date of first symptom: _____ Day / Month / Year

Date specimen taken: _____

4) How long have you lived in this city? _____

5) During the 14 days before onset of illness, have you traveled to other cities or countries? yes no don't know

Where? _____

Serum: first sample illness: _____ / / (acute - first 5 days of sickness - for virus)

second sample: _____ / / (convalescent - 6 or more days after sickness - for antibodies)

third sample: _____ / /

Other tissue: _____ / /

Comments

Criteria for DENGUE HEMORRHAGIC FEVER (#1- 4) and shock (#5)

- | | | |
|--|--|---|
| 1. Fever <input type="checkbox"/> yes <input type="checkbox"/> no | 3. Platelets $\leq 100,000/\text{mm}^3$.. <input type="checkbox"/> yes <input type="checkbox"/> no
(count) _____ | Rash <input type="checkbox"/> yes <input type="checkbox"/> no |
| 2. Any hemorrhagic manifestation | 4. Leaky capillaries | Chills <input type="checkbox"/> yes <input type="checkbox"/> no |
| Petechiae <input type="checkbox"/> yes <input type="checkbox"/> no | Pleural or abdominal effusion.. <input type="checkbox"/> yes <input type="checkbox"/> no | Nausea or vomiting ... <input type="checkbox"/> yes <input type="checkbox"/> no |
| Purpura/ Ecchymosis.. <input type="checkbox"/> yes <input type="checkbox"/> no | Lowest hematocrit _____ | Diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no |
| Vomit with blood..... <input type="checkbox"/> yes <input type="checkbox"/> no | Highest hematocrit _____ | Cough <input type="checkbox"/> yes <input type="checkbox"/> no |
| Blood in stool..... <input type="checkbox"/> yes <input type="checkbox"/> no | Lowest serum albumin _____ | Conjunctivitis <input type="checkbox"/> yes <input type="checkbox"/> no |
| Nasal bleeding..... <input type="checkbox"/> yes <input type="checkbox"/> no | Lowest serum protein _____ | Nasal Congestion <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bleeding gums..... <input type="checkbox"/> yes <input type="checkbox"/> no | 5. Lowest blood pressure _____ / _____ | Sore throat <input type="checkbox"/> yes <input type="checkbox"/> no |
| Blood in urine..... <input type="checkbox"/> yes <input type="checkbox"/> no | Other symptoms | Jaundice..... <input type="checkbox"/> yes <input type="checkbox"/> no |
| Vaginal bleeding..... <input type="checkbox"/> yes <input type="checkbox"/> no | Headache <input type="checkbox"/> yes <input type="checkbox"/> no | Convulsion or coma.. <input type="checkbox"/> yes <input type="checkbox"/> no |
| Urinalysis - over 5 RBC/hpf or positive for blood.... <input type="checkbox"/> yes <input type="checkbox"/> no | Eye pain ... <input type="checkbox"/> yes <input type="checkbox"/> no | Pregnant?..... <input type="checkbox"/> yes <input type="checkbox"/> no |
| Tourniquet test _not done _Pos_ Neg | Body pain <input type="checkbox"/> yes <input type="checkbox"/> no | YF vaccination..... <input type="checkbox"/> yes <input type="checkbox"/> no |
| | Joint pain..... <input type="checkbox"/> yes <input type="checkbox"/> no | year _____ <input type="checkbox"/> doesn't know |

FOR CDC DENGUE BRANCH USE ONLY

Specimen No. _____

S¹ _____ S² _____ S³ _____

SEROLOGY

Hemagglutination Inhibition

Test	Ag	Titer	Test	Ag	Titer	Test	Ag	Titer

IgG Antibody

Test	Ag	Qual	Titer	Test	Ag	Qual	Titer	Test	Ag	Qual	Titer

IgM Antibody

Test	Ag	Value	Test	Ag	Value	Test	Ag	Value

Neutralization

Test	Ag	Titer	Test	Ag	Titer	Test	Ag	Titer

VIROLOGY

Test	ID	Isotech	IDtech	Test	ID	Isotech	IDtech	Test	ID	Isotech	IDtech

Overall interpretation: