Form Approved OMB No. 0920-1011 Exp. Date 03/31/2017

Dengue and chikungunya report form

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)



DENGUE & CHIKUNGUNYA REPORT FORM
U.S. Virgin Islands Department of Health
Charles Harwood Complex, 3500 Estate Richmond
Christiansted, St. Croix, USVI 00820-4370
Tel. (340) 773-1311 x3241, Fax (340) 718-1508

Today's date:

Day/Month/Year

Case number Specimen # Days post onset (DPO) Type Date Received Specimen # Days post onset (DPO) Type Date Received					
SANID	GCODE \$1			\$3	
	S2			\$4	
		N			
		Please read and co	omplete ALL sect	nons	
Patient Data       Hospitalized due to this illness:       No					
F-td-t					
Name of Patient:					Fatal:
_	Last Name	First Name		Middle Name or Initial	Yes No Unk
If patient is a minor,	name of father or primary caregi	ver:			Mental status changes:
		Last Name	First Name	Middle Name or Initia	Yes No Unk Unk
Home (Physical) Address Physician who referred this case					
<u></u>			Name of Healthc	<u>are Provider:</u>	
O L			Tel:	<mark>Fax:</mark>	Email:
s he			Do you want to re	scoivo laboratory rosults vic	Fay or Email?
Do you want to receive laboratory results via Fax or Email?					
e address here address here address here address here address here and a contract here.	Zip code:	<del>-</del>	<u> </u>		
Tel:	Other Tel:				
Residence is close to:					
Work address: Patient's Demographic Information Who filled out this form?					
Date of Birth:	Age:months			Wild lilled out it its i	OIIII:
Date of Birm.	or Age:years		Name (complete)		
Day/Month/Year			Relationship with patient:  [el: Fax: Email:		
Day/Month/Year Weeks pregnant (gestation): Tel: Fax: Email:  Must have the following information for sample processing					
Day/Month/Year			How long have you lived in this city?Country of birth		
Date of first symptom	<mark></mark>		During the 14 days before onset of illness, did you TRAVEL to other cities or countries?		
<u>Date specimen taken</u> :					
First sample			Yes, another country Yes, another city No Unknown		
Second sample			WHERE did you TRAVEL?		
<u> </u>			Are there any sick contacts in your household?		
			Yes No		
PLEASE indicate below the signs and symptoms that the patient had at the time of illness					
recase indicate below the signs and symptoms that the patient had at the time of timess					
	Yes No Unk	Evidence of capillary leak	(77)	Warning signs	Yes No Unk
Fever lasting 2-7 days		Lowest hematocrit	(%)	Persistent vomiting	
Fever (>38°C/101°F)		Highest hematocrit Lowest serum	(%) albumin	Abdominal pain/Tenderne  Mucosal bleeding	
Platelets ≤100,000/mm³		Lowest serum protein	diboniin	Lethargy, restlessness	
Platelet count:		•		Liver enlargement >2cm	
Any hemorrhagic manifestation Lowest pulse pressure (SBP/DBP  Lowest pulse pressure (systolic -				Pleural or abdominal effusio	
Petechiae		Lowest white blood cell count ()	· ——	Additional symptoms	
Purpura/Ecchymosis		Symptoms	Yes No Unk	Digrrheg	
Vomit with blood		Rapid, weak pulse		Cough	
Blood in stool		Pallor or cool skin		Conjunctivitis	
Nasal bleeding		Chills		Nasal congestion	
Bleeding gums		Rash		Sore throat	
Blood in urine		Headache		Jaundice	
Vaginal bleeding Positive urinalysis		Eye pain		Convulsion or coma	
(over 5 RBC/hpf or p		Body (muscle/bone) pain		Nausea and vomiting (occo	ısional)
(2.5.0.05) (15.0)		Joint pain		Arthritis (Swollen joints)	
Tourniquet test Pos	Neg Not done	Anorexia		Missed school/work due to	his illness.
Unable to walk during this illness					
I					