Form Approved
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Dengue and chikungunya report form

DENGUE & CHIKUNGUNYA REPORT FORM

U.S. Virgin Islands Department of Health
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SUSPECTED CHIK? Yes ☐ No ☐

Today's date: _____ Day/Month/Year

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: No ☐ Yes ☐ → Hospital Name: Record Number:

Name of Patient: _____ (Last Name / First Name / Middle Name or Initial)

If patient is a minor, name of father or primary caregiver: _____ (Last Name / First Name / Middle Name or Initial)

Fatal: Yes ☐ No ☐ Unk ☐

Mental status changes: Yes ☐ No ☐ Unk ☐

Home (Physical) Address

Home address here

City: Zip code: _____-_____

Tel: Other Tel:

Residence is close to:

Work address:

Physician who referred this case

Name of Healthcare Provider:

Tel: Fax: Email:

Do you want to receive laboratory results via Fax or Email?

Patient's Demographic Information

Date of Birth: _____ Day/Month/Year

Age: _____ months Sex: M F

or Age: _____ years Pregnant: Y N UNK

Weeks pregnant (gestation): ____

Who filled out this form?

Name (complete)

Relationship with patient:

Tel: Fax: Email:

Must have the following information for sample processing

Day/Month/Year

Date of first symptom: _____

Date specimen taken:

First sample _____

Second sample _____

How long have you lived in this city? _____ Country of birth _____

During the 14 days before onset of illness, did you TRAVEL to other cities or countries?

☐ Yes, another country ☐ Yes, another city ☐ No ☐ Unknown

WHERE did you TRAVEL? _____

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

	Yes	No	Unk
Fever lasting 2-7 days			
Fever (>38°C/101°F)			
Platelets ≤100,000/mm^3			

Platelet count: _____

Any hemorrhagic manifestation

	Yes	No	Unk
Petechiae			
Purpura/Ecchymosis			
Vomit with blood			
Blood in stool			
Nasal bleeding			
Bleeding gums			
Blood in urine			
Vaginal bleeding			
Positive urinalysis (over 5 RBC/hpf or positive for blood)			

Tourniquet test ☐ Pos ☐ Neg ☐ Not done

Evidence of capillary leak

Lowest hematocrit (%)

Highest hematocrit (%)

Lowest serum albumin

Lowest serum protein _____

Lowest blood pressure (SBP/DBP) _____/_____

Lowest pulse pressure (systolic - diastolic) _____

Lowest white blood cell count (WBC) _____

Symptoms	Yes	No	Unk
Rapid, weak pulse			
Pallor or cool skin			
Chills			
Rash			
Headache			
Eye pain			
Body (muscle/bone) pain			
Joint pain			
Anorexia			

Warning signs	Yes	No	Unk
Persistent vomiting			
Abdominal pain/Tenderness			
Mucosal bleeding			
Lethargy, restlessness			
Liver enlargement >2cm			
Pleural or abdominal effusion			

Additional symptoms

Diarrhea			
Cough			
Conjunctivitis			
Nasal congestion			
Sore throat			
Jaundice			
Convulsion or coma			
Nausea and vomiting (occasional)			
Arthritis (Swollen joints)			
Missed school/work due to this illness			
Unable to walk during this illness			