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. 0920-1011
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FOR CDC DENGUE BRANCH USE ONLY

Case number

SAN ID GCODE

Specimen #	Days post onset (DPO)	Type	Date Received	Specimen #	Days post onset (DPO)	Type	Date Received
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:

Send laboratory results to (mailing address):

Patient's Demographic Information

Date of Birth: _____/_____/_____ (Day Month Year) or Age: _____ month / _____ years

Sex: M F

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:

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? _____/_____ (Month Year) ☐ Unk

Got Yellow Fever Vaccine ☐ Yes ☐ No ☐ Unk Year vaccinated _____

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

☐ Yes, another country ☐ Yes, another city ☐ No ☐ Unk

WHERE did you TRAVEL? _____

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

	Yes	No	Unk
Fever lasting 2-7 days	☐	☐	☐
Fever now(>38°C)	☐	☐	☐
Platelets ≤100,000/mm³	☐	☐	☐

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)	☐	☐	☐

FOR CDC DENGUE BRANCH USE ONLY

Specimen No.

S^1 _____ S^2 _____ S^3 _____

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: _____

Instructions to fill the Dengue Case Investigation Report

Law 81 of 1912 establishes that dengue and dengue hemorrhagic fever are reportable diseases to the Puerto Rico Department of Health. The health provider will complete in **print lettering** every question of the Dengue Case Investigation Report and will accompany the serum sample with this form. Please verify that the date of onset of symptoms and the date the serum sample was obtained are included. Without this information the sample will not be processed. On the upper left corner of the form, write the date (day, month, year) in which the report was completed.

Patient Data The complete name and information of the patient is essential because many persons have similar names and information.

- Check Yes or No to indicate whether or not the patient was hospitalized due to this illness. If the patient was hospitalized, write the name of the hospital.
- Print the name and surnames of the patient in the following order: paternal and maternal surnames, first name and middle name or initial.
- If the patient is a minor, print the name of the parent or primary caregiver. Please, write the surnames first and then the first name.
- Check if the patient died or not. If you do not know this information, check Unk for unknown.
- Check if patient presents or does not present mental status changes. This information is important because these changes could be associated with encephalitis.

Home Address Obtaining the address where the patient resides will allow us to follow-up on the patient and to implement vector control measures in specific areas as needed.

- If the patient lives in an urban area, print the name of the area, street name or number, block and house number, City/Town and ZIP code + 4 digits where patient resides.
- If the patient lives in a suburb, print the road number, kilometer, house or premise number, county, sector, City/Town and ZIP code + 4 digits where patient resides.
- If the patient lives in a condominium or public housing, print apartment number, building, name of condominium or housing complex, street, City/Town where patient resides and ZIP code + 4 digits.
- Print the patient's phone number and an alternate phone number where we could contact the patient.
- Indicate a reference point close to the patient's home (Example: next to Rivera's Grocery Store).
- If the patient has a job, write the name of the employer, including street or sector and City/Town.

Physician who referred this case This information is critical, since, by law, results will only be mailed to service providers.

- Print the name of the physician who referred the patient for a dengue test, last name first.
- Write the telephone and extension numbers, fax and Email of the physician attending the patient.
- In the block "Send laboratory results to" print the complete mailing address of the physician submitting the sample. Please, fill all blanks including the ZIP code + 4 digits to guarantee you receive the results.

Patients Demographic Information

- Write the patient's date of birth (day, month and year).
- Indicate patient's age. Write the age in months if the patient is an infant or in years if older than 1 year of age.
- Check the M box for male or F for female. If female, please indicate if the patient is pregnant and how many gestational weeks, if known.

Who filled out this form?

- Print the complete name (lat name first) of the person filling the form.
- Indicate your relationship with the patient (e.g.: mother, father, primary caregiver, physician).
- Write the phone number, fax or e-mail address.

MUST HAVE information for sample processing WITHOUT THIS INFORMATION THE SAMPLE WILL NOT BE PROCESSED.

- Day, month and year of first symptom.
- Day, month and year blood samples were taken.
- If sample is tissue, specify type of tissue (e.g. kidney, spleen, heart, etc.) to be sent to our laboratory and the date the sample was taken.

Additional Patient Data

- Indicate how many years you have lived at your current address.
- Specify country of birth
- Answer Yes, No or Unk if unknown when asked if patient has been diagnosed with dengue before.
    - If the response is Yes, indicate month and year in which the patient had dengue before this illness.
    - Check Unk if the patient does not know the date when diagnosed with dengue before.
- If the patient traveled to other countries or cities 14 days before beginning of symptoms check "Yes, another country" or "Yes, another city". If the patient did not travel or doesn't remember, check No or Unk if unknown.
- If the patient traveled, indicate country or city visited by the patient 14 days before beginning of symptoms.

Criteria for Dengue Hemorrhagic Fever, Shock and other symptoms

Check (√) the boxes to mark Yes, No, or Unk for each question related to symptoms. **Please answer ALL questions.** In the space provided:

- Write the platelet count for the last known test during this illness.
- Write the patient's lowest and highest hematocrit during this illness.
- Indicate the albumin and protein counts
- Record the lowest blood pressure during this illness - Indicate systolic and diastolic blood pressure values.
- Calculate the pulse pressure by subtracting the systolic minus diastolic. Calculate the minimal pulse pressure using the arterial pressure which subtraction results in the lowest number.
- Write the lowest White Blood Cell Count (WBC) during this illness.

Do not complete the blanks on the back of the form. These are for laboratory use only.