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

DENGUE CASE INVESTIGATION REPORT

CDC Dengue Branch and Puerto Rico Department of Health
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Form Approved OMB No. 0920-0009

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:

Fatal: ☐ Yes ☐ No ☐ Unk

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

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: _____ years

Age: _____ months

Sex: ☐ M ☐ F

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

1. How long have you lived in this city? _____
2. Country of birth _____
3. Have you been diagnosed with dengue before? ☐ Yes ☐ No ☐ Unk
4. When diagnosed? _____/_____ (Month Year) ☐ Unk
5. During the 14 days before onset of illness, did you TRAVEL to other cities or countries? ☐ Yes, another country ☐ Yes, another city ☐ No ☐ Unk
6. WHERE did you TRAVEL?

Criteria for DENGUE HEMORRHAGIC FEVER (#1-4), SHOCK (#5) and other symptoms

	Yes	No	Unk
1. Fever (>38°C)	☐	☐	☐
2. Platelets ≤100,000/mm³	☐	☐	☐

Platelet count: _____

3. 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 ☐ Not done ☐ Pos ☐ Neg

4. Evidence of capillary leak

Pleural or abdominal effusion ☐ Yes ☐ No ☐ Unk

Lowest hematocrit (%) _____

Highest hematocrit (%) _____

Lowest serum albumin _____

Lowest serum protein _____

5. Lowest blood pressure (SBP/DBP) _____/_____

Lowest pulse pressure (systolic - diastolic) _____

Other symptoms	Yes	No	Unk
Rapid, weak pulse	☐	☐	☐
Pallor or cool skin	☐	☐	☐
Headache	☐	☐	☐
Eye pain	☐	☐	☐
Body pain	☐	☐	☐

Lowest white blood cell count (WBC) _____

Other symptoms	Yes	No	Unk
Joint pain	☐	☐	☐
Rash	☐	☐	☐
Chills	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Abdominal pain	☐	☐	☐
Cough	☐	☐	☐
Conjunctivitis	☐	☐	☐
Nasal Congestion	☐	☐	☐
Sore throat	☐	☐	☐
Jaundice	☐	☐	☐
Convulsion or coma	☐	☐	☐
Pregnant?	☐	☐	☐
Got Yellow Fever Vaccine	☐	☐	☐

Year vaccinated _____ ☐

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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: _____

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 Affaire, Office of Management and Budget, Washington, DC.