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| **SUSPECTED ZIKA CASE INVESTIGATION FORM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Filled in by: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Contact number: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Date: | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Information collected from: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| ARBOVIRAL DISEASE UNDER INVESTIGATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *(Tick appropriate boxes)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ZIKA | | | | | Dengue | | | | | | | | | | | | | | | Chikungunya | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specimen submitted: | | | | | | | | | | | | | | | Blood/serum | | | | | | | | | | | | | | | | | Amniotic fluid | | | | | | | | | | | | | | | | | | | | | Foetal tissue | | | | | | | | | | | | Other, specify: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
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| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | DATE | | | | | | | | NO | YES | | |
| Age: |  | | | | | | Yrs. | | | Birth date: | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | Sex: | | | | | | | | | M F | | | | | | | | | | | Is the patient (px) pregnant? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  |  | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of last menstrual period? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |  |  | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Expected delivery date? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |  |  | | |
| Consultation: | | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Number of weeks pregnant? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  |  | | |
| Admission (whap): | | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | until | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | Any abnormalities detected on foetal ultrasound? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | |
| Treatment received: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If specimen is foetal tissue, were any foetal abnormalities detected? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If px is a neonate, does s/he have any congenital anomalies? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | |
| Hospital name (whap): | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If abnormalities/anomalies detected, describe: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | |
| Physician name: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician Tel No. | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| SYMPTOMS: *(Tick appropriate boxes)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of onset: | | | | | | | | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | And/or | | | | | | | | | Duration illness: | | | | | | | | | | | | | | | | | |  | | | | days | | | |
| Headache | | | | | | | | | | Fever | | | | | | | | | | | | | | | | Rash | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | Arthritis/arthralgia | | | | | | | | | | | | | | | | | Conjunctivitis | | | | | | | | | | | | | | | | Haemorrhage | | | | | | |
| Malaise | | | | | | | | | |  | | | | | | | | | | | | | | | | *(Site)* | | | | | | | | | | | | | | | *(Appearance)* | | | | | | | | | | | | | | | | *(Site)* | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |
| Stomachache | | | | | | | | | | Max Temp | | | | | | | | | | | | | | | | face | | | | | | | | | | | | | | | macular | | | | | | | | | | | | | | | | hands | | | | | | | | | | | | | | | | | non-purulent | | | | | | | | | | | | | | | | epistaxis | | | | | | |
| Vomiting | | | | | | | | | |  | | | | | | | | | | | °C | | | | | | arms | | | | | | | | | | | | | | papular | | | | | | | | | | | | | | | | feet | | | | | | | | | | | | | | | | | purulent | | | | | | | | | | | | | | | | haematemesis | | | | | | |
| Diarrhoea | | | | | | | | | | biphasic | | | | | | | | | | | | | | | | palms | | | | | | | | | | | | | | | petechial | | | | | | | | | | | | | | | | knees | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | melaena | | | | | | |
|  | | | | | | | | | | constant | | | | | | | | | | | | | | | | trunk | | | | | | | | | | | | | | | urticarial | | | | | | | | | | | | | | | | back | | | | | | | | | | | | | | | | | Conjunctival | | | | | | | | | | | | | | | | menorrhagia | | | | | | |
|  | | | | | | | | | | Duration (days): | | | | | | | | | | | | | | | | legs | | | | | | | | | | | | | | | pruritic | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | hyperaemia | | | | | | | | | | | | | | | | petechiae | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | soles | | | | | | | | | | | | | | | other | | | | | | | | | | | | | | | | Myalgia | | | | | | | | | | | | | | | | | Retro-orbital pain | | | | | | | | | | | | | | | | purpura | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | vene-puncture | | | | | | |
| Other: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| COMPLICATIONS: | | | | | | | | | | | Death | | | | | | | | Guillian-Barré | | | | | | | | | | | | | | | | | | | | | | | | Neurological abnormalities: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Auto-immune disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Immune-compromised/chronic illness: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| PATHOLOGICAL FINDINGS | | | | | | | | | | | | | | | | | | | | | | | *(Tick appropriate box (yes, no; UNK: unknown); Attach test results)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Differential diagnostics: | | | | | | | | | | | | | | | | | | | | | | POS | | | | | | | NEG | | | | | | | | | UNK | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | YES | | | | | NO | | | | | | UNK | | | | | | | | Additional findings: | | | | | | | | | | |
| Malaria | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Leucopenia | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | |  | | | | | | | |  | | | | | | | | |  | |
| Leptospirosis | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Lowest WBC count: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | 10^9/L | | | | | | | |  | | | | | | | | |  | |
| Rickettsia | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Thrombocytopenia | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | |  | | | | | | | |  | | | | | | | | |  | |
| Group A streptococcus | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Lowest plts. count: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | 10^9/L | | | | | | | |  | | | | | | | | |  | |
| Rubella | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Latest plts. Count: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | 10^9/L | | | | | | | |  | | | | | | | | |  | |
| Measles | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Haematocrit: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | % | | | | | | | |  | | | | | | | | |  | |
| Parvovirus | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Elevated liver function | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | |  | | | | | | | |  | | | | | | | | |  | |
| Enterovirus | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Highest ALT: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | U/L | | | | | | | |  | | | | | | | | |  | |
| Adenovirus | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | Highest AST: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | U/L | | | | | | | |  | | | | | | | | |  | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | |  | | | | | | | |  | | | | | | | | | |
| PATIENT EXPOSURE HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | NO | | | | | | | UNK | | | | | | | When? | | | | | | | | | | | | | | | | | | | | | Where? | | | | | | | | | | | | | | | | |
| Px been diagnosed with dengue before? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | |  | | | | | | | \_\_/\_\_\_\_ (month/year) | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Px received yellow fever vaccination? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | |  | | | | | | | \_\_\_\_ (year) | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Px occupation? | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Since : \_\_\_\_ (year) | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| During the past month, did patient travel? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | From: \_\_/\_\_/\_\_\_\_ | | | | | | | | Until: \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | Name of country, city or area: | | | | | | | | | | | | | | | |
| Px had recent (< 12 days) contact or bites: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | \_\_/\_\_\_\_ (month/year) | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
| Mosquito bites | | | | | | | | | | | | | | Contact + Rodent (urine, bite, wading in water) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Sexual contact | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
| Tick bite | | | | | | | | | | | | | | Contact + Monkeys or other non-human primates | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Blood transfusion | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | |

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**FAX OR EMAIL COMPLETED FORM TO:**

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