**POST COMPLETED FORM WITH SPECIMEN TO**:

Arbovirus Reference Lab, National Institute for Communicable Diseases, National Health Laboratory Service, 1 Modderfontein Road, Sandringham 2192, South Africa

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| **SUSPECTED ARBOVIRUS CASE INVESTIGATION FORM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Filled in by: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Contact number: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Date: | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | Information collected from: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
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| DISEASE(S) UNDER INVESTIGATION | | | | | | | | | | | | | | | | | | | | | | | *(Tick appropriate boxes)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sindbis | | | | | | Chikungunya | | | | | | | | | | | | West Nile | | | | | | | | | | Dengue | | | | | | | | Rift Valley | | | | | | | | | | Other arbovirus: | | | | | | | | | | | | |  | | | | | | | | | | | |
| Other suspected clinical diagnoses: | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | PATIENT COURSE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | **YES** | | | | | | **NO** | | | **DATE** | | | | | | | | |  | |
| Age: | |  | | | | | Years | | | | | | Birth date: | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | |  | | | | Patient hospitalised? | | | | | | | | | | | | | |  | | | | | |  | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | (If admitted) | |
| Sex: | | M  F | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Hospital name: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | (If admitted) | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | |  | | | | | |  | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | (If discharged) | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Severity of illness? | | | | | | | | | | | | | | Mild | | | | | | Moderate | | | | | | | | Acute/Severe | | | | | |
| Referring physician: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | Treatment(s) given? | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Number for physician: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consultation date: | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | |  | | | | Px responsive to treatment? | | | | | | | | | | | | | | | | | | | Not | | | | | Less | | | | | | | Well | | |
| CLINICAL FEATURES | | | | | | | | | | | | | | | | Date of onset: | | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | And/or | | | | | | | | Duration illness: | | | | | | | | | |  | | | | | | | days |
| Main Syndrome: | | | | | | | | | | | | | | | | *(Tick appropriate box)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fever without rash | | | | | | | | | | | | | | | | Fever with rash | | | | | | | | | | | | | Arthritis and Rash | | | | | | | | | | | | | | | | | | Encephalitis/meningitis | | | | | | | | | | | | | | | Haemorrhagic fever | | | | | | | | |
| Retinitis/conjunctivitis | | | | | | | | | | | | | | | | Other remarkable symptoms: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| If present, | | | | | Fever: | | | | | | | | | | | | Rash *(Site)* | | | | | | | | | Rash *(Appearance)* | | | | | | | | | | | | | | | | Encephalitis | | | | | | | | | | Hemorrhage | | | | | | | | | | | | | | Ocular disease | | | | |
| Describe: | | | | | Max Temp | | | | | | | | | | | | face | | | | | | | | | macular | | | | | | | | | | | | | | | | headache | | | | | | | | | | epitaxis | | | | | | | | | | | | | | pain | | | | |
|  | | | | |  | | | | | | | °C | | | | | arm | | | | | | | | | papular | | | | | | | | | | | | | | | | neck stiffness | | | | | | | | | | haematemesis | | | | | | | | | | | | | | inflammation | | | | |
|  | | | | | biphasic | | | | | | | | | | | | palms | | | | | | | | | petechial | | | | | | | | | | | | | | | | vomiting | | | | | | | | | | melaena | | | | | | | | | | | | | | blurred vision | | | | |
|  | | | | | constant | | | | | | | | | | | | trunk | | | | | | | | | urticarial | | | | | | | | | | | | | | | | confusion | | | | | | | | | | menorrhagia | | | | | | | | | | | | | | photophobia | | | | |
|  | | | | | Duration (days): | | | | | | | | | | | | legs | | | | | | | | | pruritic | | | | | | | | | | | | | | | | seizures | | | | | | | | | | petechiae | | | | | | | | | | | | | | ↓visual acuity | | | | |
|  | | | | |  | | | | | | | | | | | | soles | | | | | | | | | other | | | | | | | | | | | | | | | | unconscious | | | | | | | | | | purpura | | | | | | | | | | | | | |  | | | | |
|  | | | | |  | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | coma | | | | | | | | | | from venepuncture | | | | | | | | | | | | | |  | | | | |
| PATHOLOGICAL FINDINGS | | | | | | | | | | | | | | *(Tick appropriate box (yes, no; UNK: unknown); Attach test results)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | YES | | | | NO | | | | | UNK | | | | |  | | | | | | | | | | | | | | | | YES | | | | NO | | | | UNK | | | | | | Additional findings: | | | | | | | | | | | | | | | | |
| Malaria negative | | | | | | | | | |  | | | |  | | | | |  | | | | | Leucopenia | | | | | | | | | | | | | | | |  | | | |  | | | |  | | | | | |  | | | | | | | | | | | | | | | | |
| Thrombocytopenia | | | | | | | | | |  | | | |  | | | | |  | | | | | Lowest WBC count: | | | | | | | | | | | | | | | |  | | | | | | | | 109/L | | | | | |  | | | | | | | | | | | | | | | | |
| Lowest plts count: | | | | | | | | | |  | | | | | | | | | 109/L | | | | | Elevated liver function | | | | | | | | | | | | | | | |  | | | |  | | | |  | | | | | |  | | | | | | | | | | | | | | | | |
| Latest plts. Count: | | | | | | | | | |  | | | | | | | | | 109/L | | | | | Highest ALT: | | | | | | | | | | | | | | | |  | | | | | | | | U/L | | | | | |  | | | | | | | | | | | | | | | | |
| Haematocrit: | | | | | | | | | |  | | | | | | | | | % | | | | | Highest AST: | | | | | | | | | | | | | | | |  | | | | | | | | U/L | | | | | |  | | | | | | | | | | | | | | | | |
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| PATIENT EXPOSURE HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | NO | | | | | UNK | | | | | | | When? | | | | | | | | | | | | | | | | | Where? | | | | | | | | | | | | |
| Been diagnosed with dengue before? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  | | | | | | | \_\_/\_\_\_\_ (month/year) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Been diagnosed with Rift Valley Fever before? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  | | | | | | | \_\_/\_\_\_\_ (month/year) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Got Rift Valley Fever vaccination? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  | | | | | | | \_\_\_\_ (year) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Got Yellow Fever vaccination? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  | | | | | | | \_\_\_\_ (year) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Px occupation? | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Since : \_\_\_\_ (year) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| During the past month, did patient travel? | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  | | | | | | | From: \_\_/\_\_/\_\_\_\_ | | | | | | | Until: \_\_/\_\_/\_\_\_\_ | | | | | | | | | Outdoors Another province Another country | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | Name of place: | | | | | | | | | | | | |
| Px had recent bites/unusual animal contact? | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  | | | | | | | \_\_/\_\_\_\_ (month/year) | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Mosquito bites | | | | | | | | | | | Animal bite | | | | | | | | | | | Animal blood/tissue | | | | | | | | | | | | | | | | | Drank unpasteurized milk | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Tick bites | | | | | | | | | | | Animal saliva | | | | | | | | | | | Animal faeces/urine | | | | | | | | | | | | | | | | | Consumed uncooked meat | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Other exposures: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**FAX OR EMAIL COMPLETED FORM TO:**

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