**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

|  |
| --- |
| **SUSPECTED ARBOVIRUS CASE INVESTIGATION FORM** |
| Filled in by:  |       | Contact number: |       |
| Date:  | \_\_/\_\_/\_\_\_\_  | Information collected from:  |       |
|  |  |
| DISEASE(S) UNDER INVESTIGATION | *(Tick appropriate boxes)* |
| [ ]  Sindbis | [ ] Chikungunya | [ ] West Nile | [ ] Dengue |  [ ] Rift Valley | [ ] Other arbovirus:  |       |
| [ ] Other suspected clinical diagnoses: |       |
|  |  |  |
| 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: |       |
|       |
|       |
| 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 |       |
|  |  |  |  |  |  |  |  |
| 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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