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| **SUSPECTED YELLOW FEVER CASE HISTORY FORM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Filled in by: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Contact number: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Date: | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Information collected from: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | PATIENT COURSE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | |  | | | | | | | | | **YES** | | | | | | | | **NO** | | | | | | **DATE** | | | | | | |  | | |
| Age: | | | | |  | | | | | Years | | | | | | | | Birth date: | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | |  | | | | Patient hospitalised? | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | (If admitted) | | |
| Sex: | | M  F | | | | | | | | | | | | | | If female, pregnant? | | | | | | | | | | | | | | | YES | | | NO | | |  | | | | Hospital name: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | (If admitted) | | |
| Address: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | (If discharged) | | |
|  | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Patient is alive? | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | (If deceased) | | |
| Referring physician: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | Treatment(s) given? | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Number for physician: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| CLINICAL FEATURES AND PATHOLOGICAL FINDINGS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *(Tick appropriate box (yes; no; UNK: unknown)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date(s) of onset: | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Symptoms** | | | | | | | | **YES** | | | | | | **NO** | | | | | **UNK** | | | | | | **Signs - Complications** | | | | | | | | | | | **YES** | | | | | | | | | **NO** | | | **UNK** | | | | | | **Pathology tests** | | | | | | | | | | | | | | | | | **YES** | | | | | | | **NO** | | | **UNK** | | |
| Fever | | | °C | | | | |  | | | | | |  | | | | |  | | | | | Reduced consciousness | | | | | | | | | | | |  | | | | | | | | |  | | |  | | | | | | Malaria negative | | | | | | | | | | | | | | | | |  | | | | | | |  | | |  | | |
| Chills | | | | | | | |  | | | | | |  | | | | |  | | | | | | Jaundice - Yellow eyes | | | | | | | | | | | |  | | | | | | | | | |  | |  | | | | | | Platelets<100,000 | | | | | | | | | | | | | | | | |  | | | | | | |  | | |  | | |
| Headache | | | | | | | |  | | | | | |  | | | | |  | | | | | | Hepatomegalomy | | | | | | | | | | | |  | | | | | | | | | |  | |  | | | | | |  | | | | | | | | | | | | | | | | | **count** | | | | | | | **unit** | | | **date** | | |
| Malaise | | | | | | | |  | | | | | |  | | | | |  | | | | | | Renal failure | | | | | | | | | | | |  | | | | | | | | | |  | |  | | | | | | Lowest Plts. count: | | | | | | | | | | | | | | | | |  | | | | | | | 10^9/L | | | \_\_/\_\_/\_\_\_\_ | | |
| Nausea | | | | | | | |  | | | | | |  | | | | |  | | | | | | Arrhythmia | | | | | | | | | | | |  | | | | | | | | | |  | |  | | | | | | Lowest WBC count: | | | | | | | | | | | | | | | | |  | | | | | | | 10^9/L | | | \_\_/\_\_/\_\_\_\_ | | |
| Vomiting | | | | | | | |  | | | | | |  | | | | |  | | | | | | Rash (If yes, describe) | | | | | | | | | | | |  | | | | | | | | | |  | |  | | | | | | Lowest serum ALB: | | | | | | | | | | | | | | | | |  | | | | | | | g/L | | | \_\_/\_\_/\_\_\_\_ | | |
| Diarrhoea | | | | | | | |  | | | | | |  | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Lowest BP: | | | | | | | | | | | | | | | | |  | | | | | | | mmHG | | | \_\_/\_\_/\_\_\_\_ | | |
| Abdominal pain | | | | | | | |  | | | | | |  | | | | |  | | | | | | Petechiae /Purpura/ecchymosis | | | | | | | | | | | |  | | | | | | | | | |  |  | | | | | | | Highest C-RP: | | | | | | | | | | | | | | | | |  | | | | | | | mg/L | | | \_\_/\_\_/\_\_\_\_ | | |
| Muscle pain | | | | | | | |  | | | | | |  | | | | |  | | | | | | Overt bleeding | | | | | | | | | | | |  | | | | | | | | | |  |  | | | | | | | Highest AST: | | | | | | | | | | | | | | | | |  | | | | | | | U/L | | | \_\_/\_\_/\_\_\_\_ | | |
| Joint pain | | | | | | | |  | | | | | |  | | | | |  | | | | | | | (If yes, describe from where): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Highest ALT: | | | | | | | | | | | | | | | | |  | | | | | | | U/L | | | \_\_/\_\_/\_\_\_\_ | |
| Back pain | | | | | | | |  | | | | | |  | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | AST/ALT: | | | | | | | | | | | | | | | | |  | | | | | | | 10^9/L | | | \_\_/\_\_/\_\_\_\_ | |
| Neckstiffness | | | | | | | |  | | | | | |  | | | | |  | | | | | | | Seizures | | | | | | | | | | | |  | | | | | | | | |  | |  | | | | | | | Total Bilirubin: | | | | | | | | | | | | | | | | |  | | | | | | | mg/dL | | | \_\_/\_\_/\_\_\_\_ | |
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| Other Findings: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| PATIENT TRAVEL and EXPOSURE HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Does the patient have a history of travel outside South Africa? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| If yes, | | | | Within 30 days prior to onset? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Date(s) From: | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | Until: | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | Travelled | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | (country) | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | |  | | | |  | | | | | | | | | | | | to: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | (where within country) | | | | | | | | |
|  | | | | | | Travel purpose: | | | | | | | | | | | | | | | Holiday | | | | | | | | | Visiting relative | | | | | | | | | | | | | | | | business | | | | | | | | | | | | Other, state: | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Has the patient received any bites? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Mosquito bites | | | | | | | | | | | Tick bites | | | | | | | | | | | | Animal bites | | | | | | | | | No bites | | | | | | | | Unknown | | | | | | | | | | If yes, give date: | | | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| If yes, give details: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| PATIENT VACCINATION RECORD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Did patient receive yellow fever vaccination? *(Tick appropriate box)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (If vaccinated, specify countries and dates) | | | | | | | | | | | | | | | | | | | | | |
|  | ≥ 30 days prior to travel to yellow fever declared country | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Countries: | | | | | | | | | | | | | |  | | | | | | | |
|  | ≥ 10 days prior to travel to yellow fever declared country | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | |  | | | | | | | |
|  | < 10 days prior to travel to yellow fever declared country | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | |  | | | | | | | |
|  | Never travelled to yellow fever declared country | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Date(s): | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |
|  | Never received vaccination but travelled in past to yellow fever declared country | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Last vaccinated | | | | | | | | | | | | | | \_\_/\_\_/\_\_\_\_ | | | | | | | |
|  | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | |  | | | | | | | |

**POST COMPLETED FORM WITH SPECIMEN TO**:

Special Viral Pathogens Lab, National Institute for Communicable Diseases, National Health Laboratory Service, 1 Modderfontein Road, Sandringham 2192, South Africa

**FAX OR EMAIL COMPLETED FORM TO:**

0865964423 or cezd@nicd.ac.za