NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

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RIFT VALLEY FEVER SUSPECTED CASE INVESTIGATION FORM, 2018

Filled in by: _____ Contact number: (000) 0000000
Date: DD / MM / YYYY Information collected from: _____

PATIENT DETAILS

1. SURNAME, FIRST NAME: _____
2. AGE/DOB 00 years / DD / MM / YYYY 3. GENDER: ☐ MALE ☐ FEMALE
4. CONTACT NUMBER: (000) 0000000 (000) 0000000 (000) 0000000
5. OCCUPATION: _____ 6. FARM NAME: _____
7. TOWN: _____ DISTRICT: _____ PROVINCE: _____

CONSULTATION/ADMISSION DETAILS

8. NAME OF THE CLINICIAN: _____ 9. CELL/TEL NUMBER: (000) 0000000 (000) 0000000
10. FACILITY NAME: _____
11. DATE OF FIRST CONSULTATION: DD / MM / YYYY 12. SPECIMEN COLLECTION DATE: DD / MM / YYYY
13. ADMITTED TO HOSPITAL? ☐ Y ☐ N 14. REQUIRED ICU CARE? ☐ Y ☐ N
If yes, DURATION OF HOSPITAL ADMISSION? 00 (days) If yes, DURATION OF ICU CARE? 00 (days)

CLINICAL DETAILS ON FIRST PRESENTATION/ADMISSION

15. PAST MEDICAL HISTORY:

UNDERLYING ILLNESS? ☐ Y ☐ N … If yes, WHAT? _____
IMMUNOSUPPRESSION? ☐ Y ☐ N … If yes, GIVE DETAILS? _____
PAST RVFV INFECTION? ☐ Y ☐ N … If yes, WHEN? _____ (month) 0000 (year)

16. DATE OF ONSET OF ILLNESS? DD / MM / YYYY

17. SYMPTOMS (tick all that apply):

☐ FEVER
☐ MYALGIA
☐ ARTHRALGIA
☐ FATIGUE
☐ MALAISE
☐ LOSS OF APPETITE
☐ NAUSEA
☐ VOMITING
☐ ABDOMINAL PAIN
☐ NECK STIFFNESS
☐ HEADACHE
☐ OCULAR PAIN
☐ PHOTOPHOBIA
☐ BLURRED VISION
☐ LOSS OF VISUAL ACUITY
☐ CONFUSION

18. ☐ HAEMORRHAGE (If yes, tick sites that apply):

☐ EPISTAXIS
☐ HAEMATEMESIS
☐ MELAENA
☐ MENORRHAGIA
☐ PETECHIAE BLEEDING
☐ FROM VENEPUNCTURE SITES
☐ BLEEDING ELSEWHERE? Specify: _____

19. EXAMINATION ON PRESENTATION (tick all that apply):

☐ FEVER (≥ 38°C)
☐ SHOCK (↓BP)
☐ DEHYDRATION
☐ JAUNDICE
☐ PALLOR
☐ MENINGISM
☐ CONFUSION
☐ RETINITIS
☐ HEPATOMEGALY
☐ ABDOMINAL TENDERNESS
☐ RASH

20. LIST OTHER CLINICAL FINDINGS?

21. CLINICAL PROGRESSION TO DATE? ☐ UNEVENTFUL RECOVERY or ☐ DEVELOPED COMPLICATIONS
... If developed complications, tick all that apply:

☐ ELEVATED TRANSAMINASE LEVELS (AST, ALT)
☐ LIVER FAILURE
☐ RENAL FAILURE
☐ THROMBOCYTOPENIA
☐ HAEMORRHAGE
☐ RETINITIS
☐ ENCEPHALITIS

22. OUTCOME: ☐ ALIVE ☐ DIED … If yes, DATE OF DEATH? DD / MM / YYYY

23. EXPOSURE (tick all that apply)

DATE OF EXPOSURE? DD / MM / YYYY

☐ CONTACT WITH ANIMALS/ TISSUES
☐ MOSQUITO BITES
☐ DRANK UNPASTEURISED MILK
☐ CONSUMED ANIMAL MEAT NOT SOURCED FROM RETAIL OUTLET

DESCRIPTION OF EXPOSURE: _____

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

FAX OR EMAIL COMPLETED FORM TO:
0865964423/011 882 3741 or petrusv@nicd.ac.za / veerlem@nicd.ac.za / cezd@nicd.ac.za