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

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RIFT VALLEY FEVER SUSPECTED CASE INVESTIGATION FORM, 2020

Filled in by: _____ Contact number: (0) 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: (0) 0000000 (0) 0000000 (0) 0000000
5. Occupation: _____ 6. Farm Name: _____
7. Town: _____ District: _____ Province: _____

CONSULTATION/ADMISSION DETAILS

8. Name of the Clinician: _____ 9. Cell/Tel Number: (0) 0 (0) 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? 0 (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 RVF Infection? ☐ Y ☐ N … If yes, when? _____ (month) 0000 (year)
Unknown ☐

16. Date of onset of illness? DD / MM / YYYY or **Days since onset of illness:** 00

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
☐ None

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

☐ Epistaxis
☐ Petechiae
☐ Haematemesis
☐ Bleeding from venepuncture sites
☐ Melaena
☐ Menorrhagia
☐ Bleeding elsewhere? Specify: _____

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

☐ Fever (≥ 38°C)
☐ Shock
☐ Low Blood Pressure
☐ 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: _____

SUBMIT COMPLETED FORM WITH SPECIMEN TO:
Centre for Emerging Zoonotic and Parasitic Diseases, 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 cezd@nicd.ac.zac.za / orienkah@nicd.ac.za