

RIFT VALLEY FEVER SUSPECTED CASE INVESTIGATION FORM, 2024

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):

<input type="checkbox"/> FEVER	<input type="checkbox"/> ABDOMINAL PAIN	18. <input type="checkbox"/> HAEMORRHAGE (If yes, tick sites that apply): <input type="checkbox"/> EPISTAXIS <input type="checkbox"/> PETECHIAE BLEEDING <input type="checkbox"/> HAEMATEMESIS <input type="checkbox"/> FROM VENEPUNCTURE SITES <input type="checkbox"/> MELAENA <input type="checkbox"/> MENORRHAGIA <input type="checkbox"/> BLEEDING ELSEWHERE? Specify: _____
<input type="checkbox"/> MYALGIA	<input type="checkbox"/> NECK STIFFNESS	
<input type="checkbox"/> ARTHRALGIA	<input type="checkbox"/> HEADACHE	
<input type="checkbox"/> FATIGUE	<input type="checkbox"/> OCULAR PAIN	
<input type="checkbox"/> MALAISE	<input type="checkbox"/> PHOTOPHOBIA	
<input type="checkbox"/> LOSS OF APPETITE	<input type="checkbox"/> BLURRED VISION	
<input type="checkbox"/> NAUSEA	<input type="checkbox"/> LOSS OF VISUAL ACUITY	
<input type="checkbox"/> VOMITING	<input type="checkbox"/> CONFUSION	

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

<input type="checkbox"/> FEVER ($\geq 38^{\circ}\text{C}$)	<input type="checkbox"/> DEHYDRATION	<input type="checkbox"/> MENINGISM	<input type="checkbox"/> HEPATOMEGALY
<input type="checkbox"/> SHOCK (\downarrow BP)	<input type="checkbox"/> JAUNDICE	<input type="checkbox"/> CONFUSION	<input type="checkbox"/> ABDOMINAL TENDERNESS
	<input type="checkbox"/> PALLOR	<input type="checkbox"/> RETINITIS	<input type="checkbox"/> RASH

20. LIST OTHER CLINICAL FINDINGS?

21. CLINICAL PROGRESSION TO DATE? ☐ UNEVENTFUL RECOVERY or ☐ DEVELOPED COMPLICATIONS

... If developed complications, tick all that apply:

<input type="checkbox"/> ELEVATED TRANSAMINASE LEVELS (AST, ALT)	<input type="checkbox"/> THROMBOCYTOPENIA	<input type="checkbox"/> RETINITIS
<input type="checkbox"/> LIVER FAILURE	<input type="checkbox"/> HAEMORRHAGE	<input type="checkbox"/> ENCEPHALITIS
<input type="checkbox"/> RENAL FAILURE		

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 ☐ DRANK UNPASTEURISED MILK
☐ MOSQUITO BITES ☐ 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

EMAIL COMPLETED FORM TO:

0865964423/011 882 3741 or jessicac@nicd.ac.za / veerlem@nicd.ac.za / cezd@nicd.ac.za

RVF IN HUMANS IS A CATEGORY I NOTIFIABLE MEDICAL CONDITION IN SOUTH AFRICA