TEXAS Department of State Health Services

Arboviral Case Investigation

☐ West Nile ☐ St. Louis
☐ Chikungunya
☐ Other Arbovirus: _____

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

Patient Information

Last Name: _____ First Name _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female ☐ Unknown

Street Address: _____ City, State, Zip: _____

Patient Phone: _____ County of Residence: _____

Race: ☐ Asian ☐ American Indian/Alaskan Native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Clinical Information

Physician: _____ Address _____

City, State, Zip: _____ Phone: _____ Fax: _____

Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, provide name of hospital: _____

Dates of hospitalization: Admission ____/____/_____ Discharge ____/____/_____

Date of Illness Onset: ____/____/_____

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of death: _____ *(submit documentation if due to arbovirus)*

Clinical Evidence

Non-neurological Evidence:			
Fever	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Anorexia	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown
Retro-orbital pain	☐ Yes	☐ No	☐ Unknown
Severe malaise	☐ Yes	☐ No	☐ Unknown
Nausea/Vomiting	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown
Stiff neck	☐ Yes	☐ No	☐ Unknown
Muscle weakness	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown
Joint/Bone Pain	☐ Yes	☐ No	☐ Unknown
Rash	☐ Yes	☐ No	☐ Unknown
Vertigo	☐ Yes	☐ No	☐ Unknown

Neurological Evidence (indicated in medical record):			
Altered taste	☐ Yes	☐ No	☐ Unknown
Abnormal reflexes	☐ Yes	☐ No	☐ Unknown
Nerve palsies	☐ Yes	☐ No	☐ Unknown
Ataxia	☐ Yes	☐ No	☐ Unknown
Acute flaccid paralysis	☐ Yes	☐ No	☐ Unknown
Altered mental state	☐ Yes	☐ No	☐ Unknown
Confusion	☐ Yes	☐ No	☐ Unknown
Seizures	☐ Yes	☐ No	☐ Unknown
Paralysis	☐ Yes	☐ No	☐ Unknown
CSF pleocytosis	☐ Yes	☐ No	☐ Unknown
Myelitis	☐ Yes	☐ No	☐ Unknown
Demyelinating neuropathy (including Guillain-Barré Syndrome)	☐ Yes	☐ No	☐ Unknown
Neuritis	☐ Yes	☐ No	☐ Unknown

Is the patient pregnant?	☐ Yes	☐ No	☐ Unknown
Does the patient have an underlying chronic illness?	☐ Yes	☐ No	☐ Unknown
Is the patient immunosuppressed?	☐ Yes	☐ No	☐ Unknown
Is there a more likely clinical explanation for the patient's symptoms?	☐ Yes	☐ No	☐ Unknown

Clinical Syndrome: ☐ Febrile Illness ☐ Acute flaccid paralysis ☐ Meningitis ☐ Guillain-Barré Syndrome
☐ Encephalitis - including meningoencephalitis ☐ Other neuroinvasive

NBS Patient ID:_____ Patient Name: _____

Epidemiology

In the 30 days prior to onset, did the patient donate or receive: ☐ Blood ☐ Blood Product ☐ Organ/Tissue
Donation date: _____/_____/_____ Blood Collection Agency: _____
Transfusion/Transplant date: _____/_____/_____ Medical Facility: _____

For infants only, was the patient breastfed? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Occupation:_____
(give exact job, type of business or industry, work shift and % of time spent outside while at work)

In the 30 days prior to onset; how many hours did the patient spend outdoors each day?
☐ <2 ☐ 2-4 ☐ 5-8 ☐ >8

When outdoors, what percentage of the time did the patient use mosquito repellent?
☐ Always ☐ 75% ☐ 50% ☐ 25% ☐ Never

In the 15 days prior to illness onset, did the patient travel or reside outside of their current residence county?
☐ Yes ☐ No ☐ Unknown ***If yes, provide dates and locations on page 3.***

Is case thought to be imported from another state or country? ☐ Yes ☐ No ☐ Unknown
If yes, from where: _____

Does the patient know anyone else experiencing a similar illness? ☐ Yes ☐ No ☐ Unknown
If yes, provide names and contact information on page 3.

Transmission Mode: ☐ Vector-borne ☐ Sexual ☐ In-Utero (transplacental) ☐ Perinatal ☐ Blood borne
☐ Other (explain): _____

For Chikungunya Only:
Was the patient viremic while in Texas (during 7 days after onset)? ☐ Yes ☐ No ☐ Unknown
If yes, provide dates and locations where patient may have been bitten by mosquitoes on page 3.

Laboratory Findings

Test	Date Collected	Source	Result	Interpretation
				☐ Positive ☐ Negative ☐ Not Done
				☐ Positive ☐ Negative ☐ Not Done
				☐ Positive ☐ Negative ☐ Not Done
				☐ Positive ☐ Negative ☐ Not Done
Organism Identification	**Date Collected**	**Source**	**Result**	**Interpretation**
				☐ Positive ☐ Negative ☐ Not Done

Comments or Other Pertinent Epidemiological Data (*Use page 3 if necessary)*:

Date First Reported: ____/____/_____ Investigation: Started ____/____/_____ Completed ____/____/_____
Reporting Facility:_____
Name of Investigator:_____ *(Please print clearly)*
Agency:_____ *(Please do not abbreviate)*
Phone:_____ E-Mail:_____

NBS Patient ID:_____ Patient Name: _____

Travel Dates and Locations Prior to Illness Onset				
Dates	**Area/Street Address**	**City**	**State**	**Country**

Other Persons Experiencing Similar Illness				
Name	**Telephone Number**	**Street Address**	**City**	**State**

For Chikungunya Only: Locations of Possible Mosquito Exposure While Viremic

Estimated dates of viremia: from ____/____/_____ to ____/____/_____

Date(s)	Street Address	City	County	Comments

Additional Comments or Other Pertinent Epidemiological Data: