

# Virginia Department of Health ARBOVIRAL INFECTION CASE SURVEILLANCE WORKSHEET

## PATIENT INFORMATION

PATIENT NAME:			TELEPHONE NUMBERS:		<b>Health Department Use Only</b>  <b>VEDSS #</b>
LAST	FIRST	M. I.	Home:	Work:	
ADDRESS:			ZIP CODE:	CITY OR COUNTY OF RESIDENCE:	
DATE OF BIRTH: (mm/dd/yyyy)	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	HISPANIC ETHNICITY: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	RACE: <input type="checkbox"/> Black / African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American Indian / Alaskan Native <input type="checkbox"/> Hawaiian / Pacific Islander <input type="checkbox"/> Unknown		

## PHYSICIAN / PROVIDER INFORMATION

Name:	Phone:	FAX:
Address:		

## PATIENT CLINICAL SIGNS, SYMPTOMS AND STATUS

Was Patient Hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Admission Date: <small>mm / dd / yy</small>	Discharge Date: <small>mm / dd / yy</small>				
Illness Onset Date: <small>mm / dd / yy</small>	Hospital Name: City & State:						
<b>Signs and Symptoms</b>	Yes	No	Unk	<b>Neurological Signs</b>	Yes	No	Unk
Fever $\geq 100.4$ °F (38 °C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck / Meningeal Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue / Lethargy ← <small>If "yes", circle appropriate term(s)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flaccid Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stupor / Somnolence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myalgia / Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation / Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Lymph Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Symptoms / Signs:

Clinician's Current Diagnosis:

Patient Status: Currently ill  Recovered  Died  Unknown  If died, date of death: mm / dd / yy

## CURRENT LABORATORY FINDINGS (OTHER THAN DCLS)

Has the patient tested positive for one of the following arboviruses?	<input type="checkbox"/> WNV <input type="checkbox"/> SLE <input type="checkbox"/> LAC <input type="checkbox"/> EEE	Specimen type tested: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Other
What antibody was detected? <input type="checkbox"/> IgM <input type="checkbox"/> IgG	Date specimen collected: <small>mm / dd / yy</small>	Name of laboratory:

**Please obtain and attach to this form any relevant positive, negative or equivocal laboratory test results done by laboratories other than the Virginia Division of Consolidated Laboratory Services (DCLS).**

The most relevant laboratory results to attach include EIA or IFA serology results for arbovirus - specific IgM antibodies on serum and/or CSF.

## PATIENT RISK FACTORS DURING THE 2-WEEKS BEFORE ONSET

<b>List only travel locations where arthropod bites (e.g., mosquitoes, ticks), or risk of bites or other exposure occurred.</b>	LOCATION(S)	DATE(S)
Travel Outside USA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Travel Within U.S. or Virginia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Occupational Exposure (lab, or farm) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Animal Contact (includes mosquito, tick, bird, or other) If yes, specify species _____		
Blood Transfusion or Organ Transplant (donor or recipient) within the 2 weeks before illness onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<b>If Yes, contact VDH Office of Epidemiology Immediately</b>	

## SUBMITTING HEALTH DEPARTMENT CONTACT INFORMATION

Contact Person:	Phone:	FAX:
Health Department:		