TEXAS Health and Human Services | Texas Department of State Health Services

For Use by DSHS Central Office Only
Approved By: _____ **Date:** _____
MMWR Year: _____

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

Arboviral Case Investigation

NBS Patient ID: _____

PLEASE PRINT LEGIBLY ☐ Confirmed ☐ Probable

Patient Information

Last Name: _____ First Name: _____
Date of Birth: ____/____/_____ Age: _____ 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 and location of hospital: _____
Dates of hospitalization: Admission ____/____/_____ Discharge ____/____/_____

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

If yes, name of hospital & dates: _____

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	Diarrhea	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown	Stiff neck	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown	Muscle weakness	☐ Yes	☐ No	☐ Unknown
Anorexia	☐ Yes	☐ No	☐ Unknown	Myalgia	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown	Joint/bone pain	☐ Yes	☐ No	☐ Unknown
Retro-orbital pain	☐ Yes	☐ No	☐ Unknown	Rash	☐ Yes	☐ No	☐ Unknown
Severe malaise	☐ Yes	☐ No	☐ Unknown	Vertigo	☐ Yes	☐ No	☐ Unknown
Nausea/vomiting	☐ Yes	☐ No	☐ Unknown				

NBS Patient ID: _____ Patient Name: _____

Clinical Evidence

Neurological evidence (documented in medical record):

Altered taste	☐ Yes	☐ No	☐ Unknown	Paralysis	☐ Yes	☐ No	☐ Unknown
Abnormal reflexes	☐ Yes	☐ No	☐ Unknown	Describe paralysis	_____		
Nerve palsies	☐ Yes	☐ No	☐ Unknown	CSF pleocytosis	☐ Yes	☐ No	☐ Unknown
Ataxia	☐ Yes	☐ No	☐ Unknown	Demyelinating neuropathy (including Guillain-Barré syndrome)	☐ Yes	☐ No	☐ Unknown
Altered mental state	☐ Yes	☐ No	☐ Unknown				
Confusion	☐ Yes	☐ No	☐ Unknown				
Seizures	☐ Yes	☐ No	☐ Unknown	Neuritis	☐ Yes	☐ No	☐ Unknown

Other relevant symptoms not listed above:

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

*If yes, provide details on any **known adverse pregnancy outcomes** in comments section on Page 4.*

Does the patient have an underlying chronic illness?* ☐ Yes ☐ No ☐ Unknown

Is the patient immunosuppressed?* ☐ Yes ☐ No ☐ Unknown

Has the patient had a recent arbovirus vaccination for chikungunya, Japanese Encephalitis, Tick-borne Encephalitis, or Yellow Fever? ☐ Yes ☐ No ☐ Unknown

If yes, provide name of vaccine(s) and date(s) received:

_____

Is there a more likely clinical explanation for the patient's symptoms?* ☐ Yes ☐ No ☐ Unknown

**If yes to the questions above, provide additional information in comments section on Page 4*

Clinical syndrome: ☐ Febrile illness ☐ Acute flaccid paralysis ☐ Meningitis ☐ Guillain-Barré syndrome

(check only one) ☐ Encephalitis - including meningoencephalitis ☐ Other neuroinvasive presentation

NBS Patient ID: _____ Patient Name: _____

Epidemiology

Did the patient donate or receive blood, blood products, or organ/tissue in the 30 days before or after onset?
☐ Yes ☐ No ☐ Unknown

***If yes**:* Type of product: ☐ Blood ☐ Blood products ☐ Organ/tissue
Donation date(s): _____/_____/_____; _____/_____/_____; _____/_____/_____
Transfusion/transplant date(s): _____/_____/_____; _____/_____/_____; _____/_____/_____
Blood collection agency/medical facility: _____

For infant patients 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 ☐ Unknown

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

In the 14 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 ☐ Indeterminate ☐ 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 Type (IgM, IgG, PCR, or PRNT)	Date Collected	Performing Lab Name	Specimen Type	Result	Interpretation
					☐ Pos ☐ Equiv ☐ Neg
					☐ Pos ☐ Equiv ☐ Neg
					☐ Pos ☐ Equiv ☐ Neg
					☐ Pos ☐ Equiv ☐ Neg
					☐ Pos ☐ Equiv ☐ Neg
					☐ Pos ☐ Equiv ☐ Neg

NBS Patient ID: _____ Patient Name: _____

Comments and Other Pertinent Epidemiological Data

Date First Reported: ____/____/_____ Investigation: Started ____/____/_____ Completed ____/____/_____

Reporting Facility: _____

Name of Investigator: _____ *(Please print clearly)*

Agency: _____ *(Please do not abbreviate)*

Phone: _____ E-Mail: _____

Travel Dates and Locations <u>Prior to Illness Onset</u>

Dates	Area/Street Address	City/County	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