

Today's date: ____/____/____
Day Month Year



DENGUE CASE INVESTIGATION REPORT
CDC Dengue Branch and Puerto Rico Department of Health
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Form Approved OMB No. 0920-

FOR CDC DENGUE BRANCH USE ONLY

Case number	Specimen #	Days post onset (DPO)	Type	Date Received	Specimen #	Days post onset (DPO)	Type	Date Received
<input type="text"/>	S1			____/____/____	S3			____/____/____
<input type="text"/>	S2			____/____/____	S4			____/____/____

Please read and complete ALL sections

Patient Data	Hospitalized due to this illness: No <input type="checkbox"/> Yes <input type="checkbox"/> → Hospital Name:	Record Number:
Name of Patient: Last Name First Name Middle Name or Initial		Fatal: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>
If patient is a minor, name of father or primary caregiver: Last Name First Name Middle Name or Initial		Mental status changes: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>

Home (Physical) Address	Physician who referred this case
Name of Healthcare Provider:	
Tel: Fax: Email:	
Send laboratory results to (mailing address):	
City: Zip code: ____ - ____	
Tel: Other Tel:	
Residence is close to:	
Work address:	

Patient's Demographic Information	Who filled out this form?
Date of Birth: ____/____/____ Age: ____ month Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Name (complete)
____/____/____ or Age: ____ years Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK	Relationship with patient:
Day Month Year Weeks pregnant (gestation): ____	Tel: Fax: Email:

Must have the following information for sample processing	Additional Patient Data
Date of first symptom: ____/____/____	How long have you lived in this city? ____
Date specimen taken: ____/____/____	Country of birth ____
Serum: First sample (Acute = first 5 days of illness - check for virus) ____/____/____	Have you been diagnosed with dengue before? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Second sample (Convalescent = more than 5 days after onset - check for antibodies) ____/____/____	When diagnosed? ____/____/____ <input type="checkbox"/> Unk
Third sample ____/____/____	Got Yellow Fever Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Year vaccinated ____
Fatal cases (tissue type): ____/____/____	During the 14 days before onset of illness, did you TRAVEL to other cities or countries? <input type="checkbox"/> Yes, another country <input type="checkbox"/> Yes, another city <input type="checkbox"/> No <input type="checkbox"/> Unk
	WHERE did you TRAVEL? ____

PLEASE indicate below the signs and symptoms that the patient has at the time that this form is being completed			
Yes	No	Unk	
			Evidence of capillary leak
			Lowest hematocrit (%) ____
			Highest hematocrit (%) ____
			Lowest serum albumin ____
			Lowest serum protein ____
			Lowest blood pressure (SBP/DBP) ____/____
			Lowest pulse pressure (systolic - diastolic) ____
			Lowest white blood cell count (WBC) ____
			Symptoms
			Rapid, weak pulse ____
			Pallor or cool skin ____
			Chills ____
			Rash ____
			Headache ____
			Eye pain ____
			Body (muscle/bone) pain ____
			Joint pain ____
			Anorexia ____
			Warning signs
			Persistent vomiting ____
			Abdominal pain/Tenderness ____
			Mucosal bleeding ____
			Lethargy, restlessness ____
			Liver enlargement >2cm ____
			Pleural or abdominal effusion ____
			Additional symptoms
			Diarrhea ____
			Cough ____
			Conjunctivitis ____
			Nasal congestion ____
			Sore throat ____
			Jaundice ____
			Convulsion or coma ____
			Nausea and vomiting (occasional) ____
			Arthritis (Swollen joints) ____

FOR CDC DENGUE BRANCH USE ONLY

Specimen No.

S¹ _____S² _____S³ _____
SEROLOGY
LUMINEX (MIA)

S ¹			S ²			S ³		
Test Date	Ag	Titer	Test Date	Ag	Titer	Test Date	Ag	Titer

IgG ELISA

S ¹				S ²				S ³			
Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer

IgM ELISA

S ¹			S ²			S ³		
Test Date	Ag	P/N	Test Date	Ag	P/N	Test Date	Ag	P/N

Neutralization

S ¹			S ²			S ³		
Test Date	Screen	Titer	Test Date	Screen	Titer	Test Date	Screen	Titer
DENV-1								
DENV-2								
DENV-3								
DENV-4								
WEST NILE								
SLE								
YFV								

Viral Isolation & PCR

S ¹				S ²				S ³			
Test Date	ID	Isotech	IDtech	Test Date	ID	Isotech	IDtech	Test Date	ID	Isotech	IDtech

Serology Lab Director Signature: _____

Virology Lab Director Signature: _____ Overall dengue interpretation: _____

This questionnaire is authorized by law (Public Health Service Act 42 USC 241). Although response to the questions asked is voluntary, cooperation of the patient is necessary for the study and control of the disease. Public reporting burden for the collection of information is estimated to average 15 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to PHS Reports Clearance Officer; Rm. 721-H, Humphrey Bg; 200 Independence Ave., SW; Washington, DC 20201; ATTN: PRA, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC.

Instructions to fill the Dengue Case Investigation Report

Law 81 of 1912 establishes that dengue and dengue hemorrhagic fever are reportable diseases to the Puerto Rico Department of Health. The health provider will complete in **print lettering** every question of the Dengue Case Investigation Report and will accompany the serum sample with this form. Please verify that the date of onset of symptoms and the date the serum sample was obtained are included. Without this information the sample will not be processed. On the upper left corner of the form, write the date (day, month, year) in which the report was completed.

Patient Data The complete name and information of the patient is essential because many persons have similar names and information.

- Check Yes or No to indicate whether or not the patient was hospitalized due to this illness. If the patient was hospitalized, write the name of the hospital.
- Print the name and surnames of the patient in the following order: paternal and maternal surnames, first name and middle name or initial.
- If the patient is a minor, print the name of the parent or primary caregiver. Please, write the surnames first and then the first name.
- Check if the patient died or not. If you do not know this information, check Unk for unknown.
- Check if patient presents or does not present mental status changes. This information is important because these changes could be associated with encephalitis.

Home Address Obtaining the address where the patient resides will allow us to follow-up on the patient and to implement vector control measures in specific areas as needed.

- If the patient lives in an urban area, print the name of the area, street name or number, block and house number, City/Town and ZIP code + 4 digits where patient resides.
- If the patient lives in a suburb, print the road number, kilometer, house or premise number, county, sector, City/Town and ZIP code + 4 digits where patient resides.
- If the patient lives in a condominium or public housing, print apartment number, building, name of condominium or housing complex, street, City/Town where patient resides and ZIP code + 4 digits.
- Print the patient's phone number and an alternate phone number where we could contact the patient.
- Indicate a reference point close to the patient's home (Example: next to Rivera's Grocery Store).
- If the patient has a job, write the name of the employer, including street or sector and City/Town.

Physician who referred this case This information is critical, since, by law, results will only be mailed to service providers.

- Print the name of the physician who referred the patient for a dengue test, last name first.
- Write the telephone and extension numbers, fax and Email of the physician attending the patient.
- In the block "Send laboratory results to" print the complete mailing address of the physician submitting the sample. Please, fill all blanks including the ZIP code + 4 digits to guarantee you receive the results.

Patients Demographic Information

- Write the patient's date of birth (day, month and year).
- Indicate patient's age. Write the age in months if the patient is an infant or in years if older than 1 year of age.
- Check the M box for male or F for female. If female, please indicate if the patient is pregnant and how many gestational weeks, if known.

Who filled out this form?

- Print the complete name (last name first) of the person filling the form.
- Indicate your relationship with the patient (e.g.: mother, father, primary caregiver, physician).
- Write the phone number, fax or e-mail address.

MUST HAVE information for sample processing WITHOUT THIS INFORMATION THE SAMPLE WILL NOT BE PROCESSED.

- Day, month and year of first symptom.
- Day, month and year blood samples were taken.
- If sample is tissue, specify type of tissue (e.g. kidney, spleen, heart, etc.) to be sent to our laboratory and the date the sample was taken.

Additional Patient Data

- Indicate how many years you have lived at your current address.
- Specify country of birth
- Answer Yes, No or Unk if unknown when asked if patient has been diagnosed with dengue before.
 - If the response is Yes, indicate month and year in which the patient had dengue before this illness.
 - Check Unk if the patient does not know the date when diagnosed with dengue before.
- If the patient traveled to other countries or cities 14 days before beginning of symptoms check "Yes, another country" or "Yes, another city". If the patient did not travel or doesn't remember, check No or Unk if unknown.
- If the patient traveled, indicate country or city visited by the patient 14 days before beginning of symptoms.

Criteria for Dengue Hemorrhagic Fever, Shock and other symptoms

Check (✓) the boxes to mark Yes, No, or Unk for each question related to symptoms. **Please answer ALL questions.** In the space provided:

- Write the platelet count for the last known test during this illness.
- Write the patient's lowest and highest hematocrit during this illness.
- Indicate the albumin and protein counts
- Record the lowest blood pressure during this illness - Indicate systolic and diastolic blood pressure values.
- Calculate the pulse pressure by subtracting the systolic minus diastolic. Calculate the minimal pulse pressure using the arterial pressure which subtraction results in the lowest number.
- Write the lowest White Blood Cell Count (WBC) during this illness.

Do not complete the blanks on the back of the form. These are for laboratory use only.