Today's date: Day 10 / 24 / 2016 (Month / Day / Year)

Check suspected arboviral infection (Check all that apply): ☐ Dengue ☐ Zika ☐ Chikungunya ☐ Other _____

# ARBOVIRUS CASE INVESTIGATION FORM

Puerto Rico Public Health Laboratory, Department of Health
Building A – Second Floor, Medical Center Area
P.O. Box 70184, San Juan, PR 00926
Tel. (787)765-2929 ext. 3728, Fax (787) 274-5710

Reset Form

Estado Libre Asociado de Puerto Rico
Departamento de Salud

***Please read and complete ALL sections. See instructions on back page.***

## 1. Patient Data

Hospitalized due to this illness: No ☒ Yes ☐ → Hospital Name: Record Number:

Name of Patient: _____ (Last Name / First Name / Middle Name or Initial)

If patient is a minor, name of father or primary caregiver: _____ (Last Name / First Name / Middle Name or Initial)

Fatal: Yes ☐ No ☒ Unk ☐

Mental status changes: Yes ☐ No ☒ Unk ☐

## 2. Patient's Home (Physical) Address

Home address here

Housing Development/Building:

Number: Street:

City: Zip code: __ __ __ __ __ - __ __ __ __

Tel: Other Tel:

Residence is close to:

Work address:

## 3. Patient's Demographic Information

Date of Birth: 10 / 24 / 2016 (Month / Day / Year) or Age: _____ years _____ month

Sex: M ☐ F ☐

Pregnant: Y ☐ N ☒ UNK ☐

Weeks pregnant (gestation): ☐

Estimated Date of Delivery: Day____/Month_____/Year_____

## 4. Patient Symptom Status and Onset/Date of Specimen

Patient symptomatic? ☐ Yes ☐ No

If symptomatic, date of first symptom(s): _____ (Day / Month / Year)

Date specimen taken:

Serum sample _____

Other sample (Specify type): _____ _____

Other sample (Specify type): _____ _____

Other sample (Specify type): _____ _____

## 5. Physician contact information

Physician who ordered test - Name:

National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

Tel: Fax: Email:

Mailing address: Number: Street:

City: Zip code: __ __ __ __ __ - __ __ __ __

Hospital/Clinic/Laboratory: Specialty:

Primary care doctor- Name:

National Provider Idenifier (NPI): ☐☐☐☐☐☐☐☐☐☐

Tel: Fax: Email:

Mailing address: Number: Street:

City: Zip code: __ __ __ __ __ - __ __ __ __

Hospital/Clinic/Laboratory: Specialty:

## 6. Who filled out this form?

Name: Relationship with patient:

Tel: Fax: Email:

## 7. Additional Patient Data

Country of birth: _____

During the 14 days before onset of illness, did you TRAVEL to other municipalities, or countries?

☐ Yes, another country ☐ Yes. another municipality ☐ No ☐ Unknown

Where did you Travel? _____

## 8. Description of patient's signs and symptoms experienced at time of form completion

| | Yes | No | Unk |
|---|---|---|---|
| Fever lasting 2-7 days | ☒ | ☐ | ☐ |
| Fever now(>38ºC) | ☐ | ☒ | ☐ |
| Platelets ≤100,000/mm³ | ☐ | ☒ | ☐ |
| Platelet count: _____ | | | |
| **Any hemorrhagic manifestation** | | | |
| Petechiae | ☐ | ☒ | ☐ |
| Purpura/Ecchymosis | ☐ | ☒ | ☐ |
| Vomit with blood | ☐ | ☒ | ☐ |
| Blood in stool | ☐ | ☒ | ☐ |
| Nasal bleeding | ☐ | ☒ | ☐ |
| Bleeding gums | ☐ | ☒ | ☐ |
| Blood in urine | ☐ | ☒ | ☐ |
| Vaginal bleeding | ☐ | ☒ | ☐ |
| Positive urinalysis (over 5 RBC/hpf or positive for blood) | ☐ | ☒ | ☐ |
| Tourniquet test ☐ Pos ☐ Neg ☒ Not done | | | |

| Symptoms | Yes | No | Unk |
|---|---|---|---|
| Rapid, weak pulse | ☐ | ☒ | ☐ |
| Pallor or cool skin | ☐ | ☒ | ☐ |
| Chills | ☐ | ☒ | ☐ |
| Rash | ☐ | ☒ | ☐ |
| Headache | ☐ | ☒ | ☐ |
| Eye pain | ☐ | ☒ | ☐ |
| Body (muscle/bone) pain | ☐ | ☒ | ☐ |
| Joint pain | ☐ | ☒ | ☐ |
| Anorexia | ☐ | ☒ | ☐ |
| Encephalitis/Meningitis | ☐ | ☒ | ☐ |
| **Infant (only)** | | | |
| Microcephaly | ☐ | ☒ | ☐ |
| Intracranaial calcifications | ☐ | ☒ | ☐ |
| Other birth defect(s) | ☐ | ☒ | ☐ |
| Specify _____ | | | |
| Mother with positive or indeterminate Zika test results | ☐ | ☒ | ☐ |

| Warning signs | Yes | No | Unk |
|---|---|---|---|
| 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) | ☐ | ☒ | ☐ |

## 9. For laboratory use

Case number ☐☐☐☐☐☐

SAN ID ☐☐☐☐☐☐ GCODE ☐☐

| Specimen # | Days post onset (DPO) | Type | Date Received |
|---|---|---|---|
| S1 | | | |
| S2 | | | |
| S3 | | | |
| S4 | | | |



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## FOR PUERTO RICO DEPARTMENT OF HEALTH USE ONLY

## 10. Barcode

## Instructions for filling out Arbovirus Case Investigation Form

**General instructions: The recently amended Law 81 of 1912 establishes that dengue infection, dengue hemorrhagic fever, chikungunya infection, and Zika infection are reportable diseases to the Puerto Rico Department of Health. The health provider will write text responses in print lettering and will send this form with the patient for laboratory testing. The form should be submitted with the laboratory sample to be tested. Please fill out all sections. If sections 1–5 are not completed, the sample will not be processed!**

**Upper left corner of the form:**

- **Write the date (day, month, year) on which the report was completed.**
- **Indicate which arboviral infections are suspected. Mark all that apply.**

**Section1. Patient Data:**

- **Check "Yes" or "No" to indicate if the patient was hospitalized due to this illness. If the patient was hospitalized, write the name of the hospital and medical record number.**
- **Provide full name of patient and full name of father or primary caregiver if patient is a minor.**
- **Write 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, write 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 as such changes may be associated with encephalitis.**

**Section 2. Patient's Home Address: This information allows the PRDOH to follow-up on the patient and to take vector control measures as needed.**

- **If the patient lives in an urban area, write the name of the area, street name or number, block and house number, city/town where patient resides, and ZIP code + 4 digits.**
- **If the patient lives in a suburb, print the road number, kilometer, house or premise number, county, sector, city/town where patient resides, and ZIP code + 4 digits.**
- **If the patient lives in a condominium or public housing, write apartment number, building, name of condominium or housing complex, street, city/town where patient resides and ZIP code + 4 digits.**
- **Write 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.**

**Section 3. Patient's Demographic Information:**

- **Write the date of birth of the patient (day, month and year, in that order).**
- **Indicate age of the patient. 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.**
- **Check "Yes", "No" or "Unknown" regarding patient's pregnancy status; if pregnant, note gestational age in weeks and estimated date of delivery.**

**Section 4. Patient Symptom Status and Onset and Date of Specimen.**

- **Note if patient is symptomatic. This will help the lab determine which type of laboratory test to use.**
- **Note day, month, and year of first symptom.**
- **Note day, month, and year samples were taken and specify type of sample (blood, urine, cerebrospinal fluid, etc., or renal, splenic, or heart tissue, etc.)**

**Section 5. Physician contact information: This contact information is critical, as by law, results will only be mailed to the service provider!**

- **For the physician who ordered the test, write the physician's name, National Provider Identifier (NPI) number, telephone and extension numbers, fax, email, mailing address, name of hospital, clinic, or laboratory, and specialty. The NPI number can be obtained at https://piregistry.cms.hhs.gov/.**
- **For the primary care doctor or obstetrician, if different from the physician who ordered the test, write the same information. The results will only be shared with this (these) provider(s). It is especially critical that the obstetrician receive a pregnant woman's results.**

***SUPPLEMENTAL INFORMATION***

***Section 6. Who filled out this form?***

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

***Section 7. Additional Patient Data***

- **Specify country of birth.**
- **If the patient traveled to other countries or municipalities 14 days before beginning of symptoms, check "Yes, another country" or "Yes, another municipality". If the patient did not travel, check "no", or doesn't remember, check "Unk" if unknown. If the patient traveled, specify country or municipality visited by the patient 14 days before beginning of symptoms.**

***Section 8. Description of patient's signs and symptoms experienced at time of form completion.***

- **Check (√) the boxes to mark "Yes," "No," or "Unk" for each question related to symptoms. Please answer all questions.**
- **In the blank provided indicate platelet count.**
- **For infants only (not fetuses), mark "Yes," "No," or "Unk" related to whether infant had microcephaly, intracranial calcifications, or other birth defect (please specify which other birth defect) or if the infant's mother had positive or indeterminate Zika test results while pregnant.**

***Sections 9 and 10.*** **Do not complete these sections. For laboratory use only.**



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