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

Dengue Case Investigation

☐ Dengue-like illness
☐ Dengue
☐ Severe Dengue

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

Dengue-like Illness (reported by patient or healthcare provider):

Fever	☐ Yes	☐ No	☐ Unknown

Dengue (fever PLUS one or more of the following):

Headache	☐ Yes	☐ No	☐ Unknown
Retro-orbital pain	☐ Yes	☐ No	☐ Unknown
Nausea/Vomiting	☐ Yes	☐ No	☐ Unknown
Abdominal pain	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown
Joint/bone pain	☐ Yes	☐ No	☐ Unknown
Rash	☐ Yes	☐ No	☐ Unknown
Leukopenia (total white blood cell count <5,000mm^3)	☐ Yes	☐ No	☐ Unknown
Extravascular fluid accumulation	☐ Yes	☐ No	☐ Unknown
Positive tourniquet test	☐ Yes	☐ No	☐ Unknown
Petechiae	☐ Yes	☐ No	☐ Unknown
Purpura/Ecchymosis	☐ Yes	☐ No	☐ Unknown
Mucosal bleeding	☐ Yes	☐ No	☐ Unknown
Liver enlargement > 2 cm	☐ Yes	☐ No	☐ Unknown
Increasing hematocrit with thrombocytopenia	☐ Yes	☐ No	☐ Unknown

Severe Dengue (Dengue PLUS one or more of the following):

Severe plasma leakage with respiratory distress	☐ Yes	☐ No	☐ Unknown
Severe bleeding (i.e. melena, menorrhagia)	☐ Yes	☐ No	☐ Unknown
Severe organ involvement	☐ Yes	☐ No	☐ Unknown
Elevated liver transaminases (ALT or AST ≥ 1,000 U/L)	☐ Yes	☐ No	☐ Unknown
Impaired consciousness	☐ Yes	☐ No	☐ Unknown

NBS Patient ID: _____ Patient Name: _____

Epidemiology

Did the patient donate or receive blood, blood products, or organ/tissue in the last 30 days?
☐ 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: _____

Does this patient have a recent vaccination against a flavivirus (e.g. Yellow fever or Japanese encephalitis)? ☐ Yes ☐ No ☐ Unknown

Was the patient pregnant during illness? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Was the patient breastfeeding within 2 weeks of onset? ☐ 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

Did the patient travel outside of their residence County within 15 days of illness onset? ☐ Yes ☐ No ☐ Unknown
If yes, provide dates of travel and locations:_____

Is case thought to be imported? ☐ Yes ☐ No ☐ Unknown
If yes, from where:_____
Is this a dengue-endemic area? ☐ Yes ☐ No ☐ Unknown
Is there evidence of ongoing transmission with other flaviviruses? ☐ Yes ☐ No ☐ Unknown

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 ☐ In-Utero (transplacental) ☐ Perinatal ☐ Blood-borne
☐ Indeterminate ☐ Other (explain): _____

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

Laboratory Findings

Test (IgM, IgG, PCR, or PRNT)	Date Collected	Lab	Source	Result	Interpretation
					☐ Positive ☐ Negative
					☐ Positive ☐ Negative
					☐ Positive ☐ Negative
					☐ Positive ☐ Negative

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: _____

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

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: