DENGUE CASE INVESTIGATION REPORT

CDC Dengue Branch and Puerto Rico Department of Health
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Form Approved OMB No. 0920-0009

FOR CDC DENGUE BRANCH USE ONLY

Case number | GCODE
SAN ID

Specimen #	Days post onset (DPO)	Type	Date Received
S1			____/____/____
S2			____/____/____
S3			____/____/____
S4			____/____/____

Please complete all sections

Hospitalized: ☐ No ☐ Yes → Hospital Name:

Fatal: ☐ Yes ☐ No ☐ UNK

Name of Patient: ____________ (Last Name, First Name, Middle Name or Initial)

Mental Status Changes: ☐ Yes ☐ No ☐ UNK

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

Home Address

City, Town: Barrio:

Urbanization or sector:

Street: House / Apt. Number:

Premise No.: Box: P.O. Box:

Road No.: Km: Hm: Tel: Other Tel:

Residence is close to: Zip Code:

Work address:

Physician who referred the case

Name of Healthcare Provider:

Phone number: Email address:

Send laboratory results to:

Information about the person filling out this form

Name and title: Phone number:

Name and address of employment:

Patient's Basic Information

Date of Birth: ____/____/____ (Day Month Year)

Age: ________ months OR ________ years

Sex: ☐ M ☐ F

Must have the following information for sample processing

	Day / Month / Year
Date of first symptom:	______/______/______
Date specimen taken:	
Serum: First sample (Acute = first 5 days of illness – check for virus)	______/______/______
Second sample (Convalescent = more than 5 days after onset – check for antibodies)	______/______/______
Third sample	______/______/______
Tissue for fatal cases (specify): ________________	______/______/______

Additional Data

1. How long have you lived in this city? ____________
2. Country of birth: ____________
3. Have you been diagnosed with dengue before? ☐ Yes ☐ No ☐ UNK
4. When diagnosed? ______/______ (Month Year) ☐ UNK
5. During the 14 days before onset of illness, did you TRAVEL to other cities or countries? ☐ Yes ☐ No ☐ UNK
6. WHERE did you TRAVEL? ____________

Comments

Criteria for DENGUE HEMORRHAGIC FEVER (#1-4) and shock (#5)

	Yes	No	UNK
1. Fever (>38°C)	☐	☐	☐
2. Platelets ≤100,000/mm3	☐	☐	☐

Platelet count: ____________

3. Any hemorrhagic manifestation

	Yes	No	UNK
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 ☐ Not done ☐ Pos ☐ Neg

4. Evidence of capillary leak
   - Pleural or abdominal effusion ☐ Yes ☐ No
   - Lowest hematocrit ____________
   - Highest hematocrit ____________
   - Lowest serum albumin ____________
   - Lowest serum protein ____________
5. Lowest blood pressure ______/______
   - Lowest pulse pressure (systolic minus diastolic) ______

Lowest white blood cell count ____________

Other symptoms	Yes	No	UNK
Headache	☐	☐	☐
Eye pain	☐	☐	☐
Body pain	☐	☐	☐
Joint pain	☐	☐	☐

Symptoms continued	Yes	No	UNK
Rash	☐	☐	☐
Chills	☐	☐	☐
Pallor or cool skin	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Abdominal pain	☐	☐	☐
Cough	☐	☐	☐
Conjunctivitis (red eyes)	☐	☐	☐
Nasal Congestion	☐	☐	☐
Sore throat	☐	☐	☐
Jaundice	☐	☐	☐
Convulsion or coma	☐	☐	☐
Pregnant?	☐	☐	☐
Got Yellow Fever Vaccine	☐	☐	☐

Year vaccinated____________ ☐

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Specimen No.

S^1 ________________________________ S^2 ________________________________ S^3 (tissue or CSF) ________________________________

SEROLOGY

Hemagglutination Inhibition

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

IgG ELISA

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

IgM ELISA

S^1			S^2				S^3			
Test Date	Ag	Value	Retest Date		Ag	Value	Retest Date		Ag	Value

Neutralization

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

Viral Isolation & PCR

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

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 Affaire, Office of Management and Budget, Washington, DC.