

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	___/___/___		___/___/___
SAN ID	GCODE	S2		___/___/___	S4	___/___/___		___/___/___

Please read and complete ALL sections

**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

**Home (Physical) Address**

Home address here ↪

City: \_\_\_\_\_ Zip code: \_\_\_\_\_ - \_\_\_\_\_

Tel: \_\_\_\_\_ Other Tel: \_\_\_\_\_

Residence is close to: \_\_\_\_\_

Work address: \_\_\_\_\_

**Physician who referred this case**

Name of Healthcare Provider: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Send laboratory results to (mailing address): \_\_\_\_\_

**Patient's Demographic Information**

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ month Sex:  M  F  
or Age: \_\_\_ years Pregnant:  Y  N  UNK  
Day Month Year Weeks pregnant (gestation): \_\_\_\_\_

**Who filled out this form?**

Name (complete) \_\_\_\_\_

Relationship with patient: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Must have the following information for sample processing**

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 \_\_\_/\_\_\_/\_\_\_

Fatal cases (tissue type): \_\_\_/\_\_\_/\_\_\_

**Additional Patient Data**

How long have you lived in this city? \_\_\_\_\_

Country of birth \_\_\_\_\_

Have you been diagnosed with dengue before?  Yes  No  Unk

When diagnosed? \_\_\_/\_\_\_/\_\_\_  Unk  
Month Year

Got Yellow Fever Vaccine  Yes  No  Unk Year vaccinated \_\_\_\_\_

During the 14 days before onset of illness, did you TRAVEL to other cities or countries?  
 Yes, another country  Yes, another city  No  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		Warning signs	Yes	No	Unk
Fever lasting 2-7 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Evidence of capillary leak</b>	Persistent vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever now(>38°C).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest hematocrit (%) _____	Abdominal pain/Tenderness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Platelets ≤100,000/mm <sup>3</sup> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Highest hematocrit (%) _____	Mucosal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Platelet count: _____				Lowest serum albumin _____	Lethargy, restlessness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Any hemorrhagic manifestation</b>				Lowest serum protein _____	Liver enlargement >2cm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Petechiae.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest blood pressure (SBP/DBP) _____/____	Pleural or abdominal effusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purpura/Ecchymosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest pulse pressure (systolic - diastolic) _____				
Vomit with blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest white blood cell count (WBC) _____	<b>Additional symptoms</b>			
Blood in stool.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Symptoms</b>	Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid, weak pulse.....	Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pallor or cool skin.....	Conjunctivitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills.....	Nasal congestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash.....	Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive urinalysis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache.....	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(over 5 RBC/hpf or positive for blood)				Eye pain.....	Convulsion or coma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tourniquet test <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done				Body (muscle/bone) pain.....	Nausea and vomiting (occasional).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Joint pain.....	Arthritis (Swollen joints).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Anorexia.....				

**FOR CDC DENGUE BRANCH USE ONLY**

**Specimen No.**

S<sup>1</sup> \_\_\_\_\_ S<sup>2</sup> \_\_\_\_\_ S<sup>3</sup> \_\_\_\_\_

**SEROLOGY  
LUMINEX (MIA)**

S <sup>1</sup>			S <sup>2</sup>			S <sup>3</sup>		
Test Date	Ag	Titer	Test Date	Ag	Titer	Test Date	Ag	Titer

**IgG ELISA**

S <sup>1</sup>				S <sup>2</sup>				S <sup>3</sup>			
Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer	Test Date	Ag	Screen	Titer

**IgM ELISA**

S <sup>1</sup>			S <sup>2</sup>			S <sup>3</sup>		
Test Date	Ag	P/N	Test Date	Ag	P/N	Test Date	Ag	P/N

**Neutralization**

S <sup>1</sup>			S <sup>2</sup>			S <sup>3</sup>		
Test Date	Screen	Titer	Test Date	Screen	Titer	Test Date	Screen	Titer
DENV-1								
DENV-2								
DENV-3								
DENV-4								
WESTNILE								
SLE								
YFV								

**Viral Isolation & PCR**

S <sup>1</sup>				S <sup>2</sup>				S <sup>3</sup>			
Test Date	ID	Iso tech	IDtech	Test Date	ID	Iso tech	IDtech	Test Date	ID	Iso tech	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 Office, Rm. 721-H, Humphrey Bldg, 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.**