

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



DENGUE CASE INVESTIGATION REPORT
 CDC Dengue Branch and Puerto Rico Department of Health
 1324 Calle Cañada, San Juan, P. R. 00920-3860
 Tel. (787) 706-2399, Fax (787) 706-2496



Form Approved OMB No. 0920-0009

FOR CDC DENGUE BRANCH USE ONLY

| | | | | | | | | |
|-------------|------------|-----------------------|------|---------------|------------|-----------------------|------|---------------|
| Case number | Specimen # | Days post onset (DPO) | Type | Date Received | Specimen # | Days post onset (DPO) | Type | Date Received |
| | S1 | | | | S3 | | | |
| SAN ID | G CODE | | | | | | | |
| | S2 | | | | S4 | | | |

Please read and complete ALL sections

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

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: ____ months Sex: M F
 or Age: ____ years

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
- 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? _____

Criteria for DENGUE HEMORRHAGIC FEVER (#1-4), SHOCK (#5) and other symptoms

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------|--------------------------|----|-----|-------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------------------------|---|--|-----|----|-----|------------|--------------------------|--------------------------|--------------------------|------|--------------------------|--------------------------|--------------------------|--------|--------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------------------|---------|--------------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--|--|
| <p>1. Fever (>38°C) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>2. Platelets ≤100,000/mm³ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Platelet count: _____</p> <p>3. Any hemorrhagic manifestation</p> <p>Petechiae <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Purpura/Ecchymosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Vomit with blood <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Blood in stool <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Nasal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Vaginal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Positive urinalysis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <small>(over 5 RBC/hpf or positive for blood)</small></p> | <p>Toumiquet test <input type="checkbox"/> Not done <input type="checkbox"/> Pos <input type="checkbox"/> Neg</p> <p>4. Evidence of capillary leak</p> <p>Pleural or abdominal effusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Lowest hematocrit (%) _____</p> <p>Highest hematocrit (%) _____</p> <p>Lowest serum albumin _____</p> <p>Lowest serum protein _____</p> <p>5. Lowest blood pressure (SBP/DBP) ____/____</p> <p>Lowest pulse pressure (systolic - diastolic) _____</p> <p>Other symptoms</p> <table border="1"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>Unk</td> </tr> <tr> <td>Rapid, weak pulse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Pallor or cool skin</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Headache</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Eye pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Body pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>Lowest white blood cell count (WBC) _____</p> | | Yes | No | Unk | Rapid, weak pulse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pallor or cool skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Body pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <p>Other symptoms</p> <table border="1"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>Unk</td> </tr> <tr> <td>Joint pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Rash</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Chills</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Nausea or vomiting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Diarhea</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Abdominal pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Cough</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Conjunctivitis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Nasal Congestion</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sore throat</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Jaundice</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Convulsion or coma</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Pregnant?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Got Yellow Fever Vaccine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Year vaccinated _____</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table> | | Yes | No | Unk | Joint pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rash | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Conjunctivitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nasal Congestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sore throat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsion or coma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Got Yellow Fever Vaccine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Year vaccinated _____ | <input type="checkbox"/> | | |
| | Yes | No | Unk | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rapid, weak pulse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pallor or cool skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eye pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Body pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Yes | No | Unk | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Joint pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rash | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nausea or vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diarhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conjunctivitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nasal Congestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sore throat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Convulsion or coma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Got Yellow Fever Vaccine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Year vaccinated _____ | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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 |
| | | | | | | | | |
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| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

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.