Tennessee Department of Health
Arboviral Disease Form

Revised: 04/2018

Please fill out this form as completely as possible and send or fax to Central Office: Tennessee Department of Health
Vector Borne Disease Program, 630 Hart Lane, Nashville, TN 37216
Phone: 615.262.6356 Fax: 615.262.6324

Demographics

CASE ID#:_____

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____
Reported Age: _____ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown
Street Address: _____
City: _____ **County:** _____ **State:** _____ **Zip:** _____
Phone - Home: _____ **Work:** _____ **Cell:** _____
Ethnicity: □ Hispanic □ Not Hispanic **Race:** □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Other

Investigation Summary

INVESTIGATION

***Disease :** □ **Chikungunya** □ **Dengue** □ **Severe Dengue**
□ **Dengue-like** □ **La Crosse Neuro.** □ **La Crosse Non Neuro.**
□ **West Nile Neuro.** □ **West Nile Non Neuro**
□ **Other** _____
***Jurisdiction**_____
Investigation Start Date: _____/_____/_____
***Investigation Status:** □ **Open** □ **Closed**
Investigator:_____

HOSPITAL

Physician: _____
Was the patient hospitalized for this illness? □ Yes □ No □ Unknown
If yes, **Hospital:** _____
Admission:____/____/____ **Discharge:** ____/___/____
***Illness Onset Date:** ___/___/___ **Illness End Date:** ____/____/___
Is the patient pregnant? □ Yes □ No □ Unknown
Did the patient die from this illness?
□ Yes (Date of death ____/____/____) □ No □ Unknown

Laboratory

ORDER INFO

***Reporting Facility:** _____ City/ State: _____
Ordering Facility: _____ City/ State: _____
Ordering Provider: _____ City/ State: _____
Lab Report Date: ___/___/____ ***Date Received by Public Health:** ___/____/_____ Ordered Test:_____

TEST RESULT (S)

Resulted Test	Pathogen	Coded Result 1	Numeric Result 1	Date Collected 1	Coded Result 2	Numeric Result 2	Date Collected 2
IFA IgG		□ Pos □ Neg			□ Pos □ Neg		
IFA IgM		□ Pos □ Neg			□ Pos □ Neg		
EIA/ELISA IgG		□ Pos □ Neg			□ Pos □ Neg		
EIA/ELISA IgG		□ Pos □ Neg			□ Pos □ Neg		

CSF IgM: □ Pos □ Neg (Collected: ___/___/___) **PCR:** □ Pos □ Neg (Collected: ___/___/___) **PRNT** □ Pos □ Neg (Collected: ___/___/___)

Clinical Information

SYMPTOMS

□ Aphasia
□ Behavioral changes
□ Confusion
□ Cough
□ Diarrhea
□ Epistaxis
□ Eye pain
□ Fever
□ Fever lasting 2—7 days
□ Headache
□ Hematuria
□ Jaundice
□ Joint Pain
□ Leukopenia
□ Loss of consciousness
□ Muscle aches
□ Photophobia
□ Plasma leakage
□ Profound weakness
□ Purpura/ Echymosis
□ Rash
□ Seizures
□ Sore Throat
□ Stiff Neck
□ Vomiting

OTHER

Sources of Infection (select all that apply - Y=Yes, N=No, U=Unknown):

Y	N	U		Y	N	U	
□	□	□	Occupationally lab acquired	□	□	□	Non-ocupationally lab acquired
□	□	□	**Blood transfusion received***	□	□	□	**Blood donor***
□	□	□	**Identified by blood donor screening***	**Donation date: ___/____/___)**			
□	□	□	**Organ donor***	□	□	□	**Organ transplant received***
□	□	□	Breastfed Infant	□	□	□	Infected in Utero

***In the last 30 days since symptom onset**

Did the patient travel outside home county in the 4 weeks before symptom onset?
□ **Yes** (Where/Date:_____) □ **No**
Was the patient part of a group trip?
□ Yes (What group:_____) □ No
Group Coordinator (Name/phone:_____)
Any known ill contacts (Name/phone:_____)

<u>*Clinical Syndrome</u>
<u>(must choose one for all arboviruses except Dengue):</u>

Neuroinvasive Clinical Syndrome
□ Acute Flaccid Paralysis (AFP) without Encephalitis or Meningitis†
□ Encephalitis - including meningoencephalitis (with or without AFP)
□ Meningitis (with or without AFP)
†If patient has AFP without encephalitis/meningitis choose "Other Clinical Syndrome" in NBS.

Non-Neuroinvasive Clinical Syndrome
□ Asymptomatic (for tissue and blood donors with no symptoms)
□ Febrile Illness
□ Hepatitis/Jaundice
□ Multi organ failure
□ Other clinical

***Case Status (see case definition for details)**

□ **Confirmed** □ **Suspect** □ **Probable** □ **Not a Case**