

**Tennessee Department of Health
Arboviral Disease Form**

Please fill out this form as completely as possible.
***Answers must be entered into NBS for text in red.** Once complete, send or fax the form to:

Revised: 6/2015

**Tennessee Department of Health,
Vector-Borne Diseases**
630 Hart Lane, Nashville, TN 37216
Phone: 615.262.6356 Fax: 615.262.6324

DEMOGRAPHICS

CASE ID#: _____ (internal)

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

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: _____
 Specimen Source: _____ Accession Number: _____ Patient Status: Hospitalized Outpatient Unk.

TEST RESULT(S)	*Resulted Test	Patho- gen	Coded Result 1	Numeric Result 1	Date Collected 1	Coded Result 2	Numeric Result 2	Date Collected 2
		IFA IgG		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		____/____/____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
	IFA IgM		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		____/____/____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		____/____/____
	EIA/ELISA IgG		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		____/____/____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		____/____/____
	EIA/ELISA IgM		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		____/____/____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		____/____/____

CSF: Pos Neg (Collected: ____/____/____) PCR: Pos Neg (Collected: ____/____/____) PRNT: Pos Neg (Collected: ____/____/____)

INVESTIGATION SUMMARY

INVESTIGATION	*Disease: <input type="checkbox"/> Dengue <input type="checkbox"/> Severe Dengue <input type="checkbox"/> Dengue-like <input type="checkbox"/> Chikungunya <input type="checkbox"/> La Crosse <input type="checkbox"/> West Nile Neuro. <input type="checkbox"/> West Nile Non-Neuro. <input type="checkbox"/> Other _____	HOSPITAL	Physician: _____
	*Jurisdiction: _____		Was the patient hospitalized for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Hospital: _____ Diagnosis Date: ____/____/____
	Investigation Start Date: ____/____/____		*Illness Onset Date: ____/____/____ Illness End Date: ____/____/____
	*Investigation Status: <input type="checkbox"/> Open <input type="checkbox"/> Closed		Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Investigator: _____		Did the patient die from this illness? <input type="checkbox"/> Yes (Date of death: ____/____/____) <input type="checkbox"/> No <input type="checkbox"/> Unknown

CLINICAL INFORMATION

SYMPTOMS	<input type="checkbox"/> Aphasia <input type="checkbox"/> Fever lasting 2 - 7 days <input type="checkbox"/> Photophobia <input type="checkbox"/> Behavioral Changes <input type="checkbox"/> Headache <input type="checkbox"/> Plasma leakage <input type="checkbox"/> Confusion <input type="checkbox"/> Hematuria <input type="checkbox"/> Profound Weakness <input type="checkbox"/> Cough <input type="checkbox"/> Jaundice <input type="checkbox"/> Purpura/Echymosis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Joint Pain <input type="checkbox"/> Rash <input type="checkbox"/> Epistaxis <input type="checkbox"/> Leukopenia <input type="checkbox"/> Seizures <input type="checkbox"/> Eye Pain <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Fever <input type="checkbox"/> Muscle aches <input type="checkbox"/> Stiff Neck (max. temp.: _____) <input type="checkbox"/> Nausea <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Vomiting	<p>*Clinical Syndrome <u>(must choose one for all arboviruses except Dengue)</u> — See 'Arboviral Clinical Syndrome Guidelines' for details. —</p> <p>Neuroinvasive Clinical Syndromes: <input type="checkbox"/> Acute Flaccid Paralysis (AFP) without Encephalitis or Meningitis[†] <input type="checkbox"/> Encephalitis—Including Meningoencephalitis (with or without AFP) <input type="checkbox"/> Meningitis (with or without AFP)</p> <p>[†] If patient has AFP without encephalitis or meningitis, choose 'Other Clinical' as the clinical syndrome in NBS.</p>
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OTHER	Sources of Infection (select all that apply — Y=Yes, N=No, U=Unknown): Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Occupationally Lab Acquired <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-Occupationally Lab Acquired <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Blood Transfusion Received <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood Donor <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Identified by Blood Donor Screening Date of Blood Donation: ____/____/____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Organ Donor <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Organ Transplant Received <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Breastfed Infant <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Infected in Utero	<p>Non-Neuroinvasive Clinical Syndromes: <input type="checkbox"/> Asymptomatic (for tissue and blood donors with no symptoms) <input type="checkbox"/> Hepatitis/Jaundice <input type="checkbox"/> Multi organ failure <input type="checkbox"/> Other Clinical <input type="checkbox"/> Uncomplicated fever (fever without neuro. involvement) <input type="checkbox"/> Unknown</p>
	Did the patient travel outside home county in the two weeks before symptom onset? <input type="checkbox"/> Yes (Where/Date: _____) <input type="checkbox"/> No Was the patient part of a Group Trip? <input type="checkbox"/> Yes (What group: _____) <input type="checkbox"/> No Group Coordinator (Name/phone: _____) Any known ill Contacts (Name/phone: _____)	<p>*CASE STATUS (SEE CASE DEFINITION FOR DETAILS)</p> <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspect <input type="checkbox"/> Probable <input type="checkbox"/> Not a Case