WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Arboviral Infection

(Do not use this form for dengue fever or yellow fever)

PATIENT DEMOGRAPHICS

*NAME (last, first): ____________________

*ADDRESS (mailing): ____________________

*ADDRESS (physical): ____________________

*City/State/Zip: ____________________

*PHONE (home): ____________ Phone (work/cell) : ____________

Alternate contact: ☐Parent/Guardian ☐Spouse ☐Other

Name: ____________________ *Phone:* ____________

*Birth date: __ / __ / ____ *Age: _____

*Sex: ☐Male ☐Female ☐Unk

*Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

*Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐ Native HI/Other PI ☐Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): ____________________

Investigation Start Date:__ / __ / ____

Earliest date reported to LHD: __ / __ / ____

Earliest date reported to DIDE: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk

Case Classification:

☐ Confirmed ☐ Probable ☐ Suspect

☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other

Reporter Name: ____________________ Reporter Phone: ____________________

Primary HCP Name: ____________________ Primary HCP Phone: ____________________

CLINICAL

***Onset date**: __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

*Arbovirus Reported (if not below, list: ____________)

☐Eastern Equine **(EEE)** ☐La Crosse **(LAC)** ☐Powassan **(POW)**

☐Western Equine **(WEE)** ☐St. Louis **(SLE)** ☐West Nile **(WNV)**

☐Zika Virus (**ZIK**) ☐Chikungunya (**CHK**)

*Clinical Findings

Y N U

☐ ☐ ☐ Fever (Highest measured temperature: _____ °F)

☐ ☐ ☐ Meningitis

☐ ☐ ☐ Encephalitis

☐ ☐ ☐ Myelitis

☐ ☐ ☐ Stupor

☐ ☐ ☐ Coma

☐ ☐ ☐ Paresis

☐ ☐ ☐ Acute flaccid paralysis

☐ ☐ ☐ Nerve palsies

☐ ☐ ☐ Abnormal reflexes

☐ ☐ ☐ Abnormal movements

☐ ☐ ☐ Convulsions

☐ ☐ ☐ Arthralgia

☐ ☐ ☐ Conjunctivitis

Clinical Risk Factors

Y N U

☐ ☐ ☐ Underlying medical condition

☐ ☐ ☐ Immune suppression

Hospitalization

Y N U

☐ ☐ ☐ Patient hospitalized for this illness

If yes, hospital name: ____________________

Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Death

Y N U

☐ ☐ ☐ Patient died due to this illness

If yes, date of death: __ / __ / ____

VACCINATION HISTORY

Y N U

☐ ☐ ☐ Ever vaccinated for yellow fever (If yes, date: __ / __ / ____)

☐ ☐ ☐ Ever vaccinated for Japanese encephalitis (If yes, date: __ / __ / ____)

☐ ☐ ☐ Ever vaccinated for tickborne encephalitis (If yes, date: __ / __ / ____)

LABORATORY *(Please submit copies of all labs, including CSF studies associated with this illness to DIDE)*

Y N U

☐ ☐ ☐ *Elevated white blood cell count (>5 WBCs adjusting for RBCs by subtracting 1 WBC for every 500 RBCs) in CSF specimen

☐ ☐ ☐ * Elevated protein in CSF specimen

☐ ☐ ☐ *Isolation of specific arbovirus or demonstration of specific arbovirus antigen or nucleic acid

☐ ☐ ☐ *Four-fold or greater change in arbovirus-specific quantitative antibody titer in paired sera

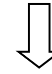
☐ ☐ ☐ *Arbovirus-specific IgM antibodies in serum **with** virus-specific neutralizing antibodies in same or later specimen (PRNT)

☐ ☐ ☐ *Arbovirus-specific IgM antibodies in CSF **with** negative result for other IgM antibodies in CSF to other arboviruses

☐ ☐ ☐ *Arbovirus-specific IgM antibodies in serum or CSF **with no further testing**

INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period

	Exposure period		Onset date
Days from onset	______ *(Enter Max Incubation)**	______ *(Enter Min Incubation)**	
Calendar dates:	__/__/____	__/__/____	__/__/____

EPIDEMIOLOGIC EXPOSURES (based on the above exposure period, unless otherwise specified)

Y N U
☐ ☐ ☐ History of travel during exposure period (if yes, complete travel history below):

Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for travel

Y N U
☐ ☐ ☐ Artificial water-holding containers present near residence
☐ ☐ ☐ Areas of standing water present near residence
☐ ☐ ☐ Hardwood forest present near residence
☐ ☐ ☐ Poorly draining gutters present near residence
☐ ☐ ☐ Window/door screens in disrepair or missing at residence

***Geographic coordinates of patient residence:**
Latitude: ______________ **Longitude:** ________________
(Indicate units:
☐Decimal Degrees ☐Degrees Minutes Seconds ☐Other)

Y N U
☐ ☐ ☐ Blood transfusion 30 days prior to onset (Date:__/__/____)
☐ ☐ ☐ Organ transplant 30 days prior to onset (Date:__/__/____)
☐ ☐ ☐ Case was prenatally exposed (in utero)
☐ ☐ ☐ Case is a breast-fed infant
☐ ☐ ☐ Outdoor recreational activities (e.g. hiking, camping, etc)
☐ ☐ ☐ Mosquito bite
☐ ☐ ☐ Tick bite (if Powassan or other tickborne arbovirus)
☐ ☐ ☐ Possible occupational exposure
☐ Laboratory worker (Date of exposure:__/__/____)
☐ Other occupation: ___________________________

Where did exposure most likely occur? **County:** ______________ **State:**________ **Country:** _______________

PUBLIC HEALTH ISSUES

Y N U
☐ ☐ ☐ Case identified through blood donor screening
☐ ☐ ☐ Case donated blood products, organs or tissue in the 30 days prior to symptom onset
Date:__/__/____
Agency/location:___________________
Type of donation:__________________
☐ ☐ ☐ Case is pregnant (Due date: __/__/____)
☐ ☐ ☐ Case knows someone who had shared exposure and is currently having similar symptoms
☐ ☐ ☐ Epi link to another confirmed case of same condition
☐ ☐ ☐ Case is part of an outbreak
☐ ☐ ☐ Other:

PUBLIC HEALTH ACTIONS

Y N U
☐ ☐ ☐ Notify blood or tissue bank or other facility where organs donated
☐ ☐ ☐ Notify patient obstetrician
☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian
☐ ☐ ☐ Recommended environmental measures to patient/family to reduce risk around home
☐ ☐ ☐ Education or outreach provided to employer
☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a shared exposure
☐ ☐ ☐ Patient is lost to follow-up
☐ ☐ ☐ Other:

WVEDSS

Y N U
☐ ☐ ☐ Entered into WVEDSS (**Entry date**: __/__/____) **Case Status:** ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

NOTES

*Incubation Periods:
EEE= 4-10 days **LAC**= 5-15 days **POW**= 7-28 days **WEE**= 5-15 days **WNV**= 2-14 days **SLE**= 5-15 days **CHIK**= 3-7 days **ZIK**= 2-7 days