

Nebraska DHHS
Arboviral Disease Form

Please fill out this form as completely as possible.
*Answers must be entered into NEDSS for text in red. Once complete, send or fax the form to:
Revised: 8/2014

Nebraska Division of Public Health,
Office of Epidemiology
P.O. Box 95026, Lincoln, NE 68516
Phone: 402.471.2937 Fax: 402.471.3601

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 Fever <input type="checkbox"/> Dengue Hemor. Fever <input type="checkbox"/> Chikungunya <input type="checkbox"/> Other _____ <input type="checkbox"/> West Nile Neuro. <input type="checkbox"/> West Nile Non-Neuro. <input type="checkbox"/> La Crosse <input type="checkbox"/> St. Louis Encephalitis	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 Investigator: _____		Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 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 (must choose one) — 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) [†] If patient has AFP without encephalitis or meningitis, choose 'Other Clinical' as the clinical syndrome in NBS.</p> <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> <p>Dengue Clinical Syndromes: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Dengue Fever <input type="checkbox"/> Dengue with Hemorrhage <input type="checkbox"/> Dengue Hemorrhagic Fever/Dengue Shock Syndrome <input type="checkbox"/> Uncomplicated fever (fever without criteria for above dengue syn.) <input type="checkbox"/> Unknown</p>											
	<p>Sources of Infection (select all that apply — Y=Yes, N=No, U=Unknown):</p> <table border="0"> <tr> <td>Y N U</td> <td>Y N U</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Occupationally Lab Acquired</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-Occupationally Lab Acquired</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Blood Transfusion Received</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood Donor</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Identified by Blood Donor Screening</td> <td>Date of Blood Donation: ____/____/____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Organ Donor</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Organ Transplant Received</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Breastfed Infant</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Infected in Utero</td> </tr> </table> <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>	Y N U	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
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