MONTANA DPHHS

NOT for West Nile Virus disease or Yellow Fever

Send completed forms to DPHHS CDEpi Program
Fax: 800-616-7460

LHJ Use ID _____
☐ Reported to DPHHS Date ___/___/___
LHJ Classification ☐ Confirmed ☐ Probable
By: ☐ Lab ☐ Clinical ☐ Epi Link: _____

☐ Outbreak-related
*LHJ Cluster#*_____
LHJ Cluster Name: _____
DPHHS Outbreak # _____

Arboviral Disease

County

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
Reporter (check all that apply) ☐ Lab ☐ Hospital ☐ HCP ☐ Public health agency ☐ Other

Date of interview ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Zip code (school or occupation): _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian ☐ Native HI/other PI ☐ Black/Afr Amer ☐ White ☐ Other ☐ Unk

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Type of arboviral disease: *(Record in species/organism in PHIMS)*
☐ Western equine encephalitis ☐ Eastern equine encephalitis
☐ St. Louis encephalitis ☐ Japanese encephalitis
☐ Dengue ☐ LaCrosse encephalitis
☐ Other: _____ *Do not use this form for WNV or Yellow fever*

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Fever** # days:____ Highest meas'd temp:_____°F
☐	☐	☐	☐	Nausea or vomiting
☐	☐	☐	☐	**Headache**
☐	☐	☐	☐	**Stiff neck**
☐	☐	☐	☐	Eyes sensitive to light (photophobia)
☐	☐	☐	☐	Muscle aches or pain (myalgia)
☐	☐	☐	☐	Joint pain (arthralgia)
☐	☐	☐	☐	Rash

Predisposing Conditions

☐	☐	☐	☐	Previous flavivirus infection (e.g., dengue, SLE)
☐	☐	☐	☐	Underlying chronic illness or immunosuppressed

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Rash observed by health care provider
☐	☐	☐	☐	Arthritis
☐	☐	☐	☐	Jaundice or hepatitis
☐	☐	☐	☐	Kidney (renal) abnormality or failure
☐	☐	☐	☐	Multiple organ failure
☐	☐	☐	☐	**Acute flaccid paralysis (neuroinvasive)**
☐	☐	☐	☐	**Other neuroinvasive**:

☐ Altered mental status (disorientation, stupor)
☐ Meningitis ☐ Encephalitis / meningoencephalitis
☐ Limb weakness (documented by HCP)
☐ Ataxia ☐ Abnormal reflexes ☐ Seizures (new)
☐ Paresis ☐ Other acute abnormality:_____

☐	☐	☐	☐	**Hemorrhagic signs**: ☐ Positive tourniquet test

☐ Petechiae ☐ Purpura/ecchymosis ☐ Epistaxis
☐ Gum bleeding ☐ Blood in vomitus, stool, urine
☐ Vaginal bleeding ☐ Nasal bleeding ☐+ urinalysis

☐	☐	☐	☐	**Plasma leakage or pleural effusion or ascites**
☐	☐	☐	☐	**Shock syndrome** (hypotension, clammy skin, rapid pulse)
☐	☐	☐	☐	Complications, specify: _____
☐	☐	☐	☐	Admitted to intensive care unit

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized at least overnight for this illness

Hospital name _____
Admit date ___/___/____ Discharge date ___/___/____

☐	☐	☐	☐	Died from illness Death date ___/___/____
☐	☐	☐	☐	Autopsy Place of death _____

Vaccinations

Y	N	DK	NA	
☐	☐	☐	☐	Japanese encephalitis or yellow fever vaccine in past Type: _____ Date ___/___/___

Laboratory

P=Positive N=Negative I=Indeterminate O=Other NT=Not Tested

Specimen type _____ Collection date ___/___/___
Specimen type _____ Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	**Thrombocytopenia** (<100K platelets/mm^3)
☐	☐	☐	☐	☐	Abnormal CSF profile: wbc ____ (% lymph____; % neutr____) rbc ____ prot ____ gluc ____
☐	☐	☐	☐	☐	**Pleocytosis** (increased WBC in CSF)

Dengue-specific labs

☐	☐	☐	☐	☐	**Dengue: IgM + (P/N >2)** (single serum) **[Probable]**
☐	☐	☐	☐	☐	**Dengue: Viral culture or PCR** (clinical specimen)
☐	☐	☐	☐	☐	**Dengue: IgM seroconversion** (acute <5 d; conv ≥5 d)
☐	☐	☐	☐	☐	**Dengue: IgG with ≥ 4-fold rise** (serum pair)
☐	☐	☐	☐	☐	**Dengue: ≥4-fold difference between dengue and other flaviviruses by PRNT** (single conv. serum)
☐	☐	☐	☐	☐	**Dengue: IgM in CSF**

Other arbovirus labs

☐	☐	☐	☐	☐	**Other: IgM in serum by EIA/MIA/IFA [Probable]**
☐	☐	☐	☐	☐	**Other: IgM in CSF by EIA/MIA/IFA [Probable]**
☐	☐	☐	☐	☐	**Other: Virus culture or PCR** (clinical specimen)
☐	☐	☐	☐	☐	**Other: ≥4-fold rise in quantitative titer** (serum pair)
☐	☐	☐	☐	☐	**Other: IgM in serum with confirmatory assay (e.g., PRNT) in same or later specimen**
☐	☐	☐	☐	☐	**Other: Virus-specific IgM in CSF and negative IgM result for other arboviruses**

Tested at: ☐ MT PHL ☐ CDC ☐ Other PHL ☐ Commercial ☐ Other

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period		
Days from onset:	-15	-2	onset
Calendar dates:			

EXPOSURE (Refer to dates above)

Y	N	DK	NA	
☐	☐	☐	☐	Travel out of the state, out of the country, or outside of usual routine Out of: ☐ County ☐ State ☐ Country Dates/Locations: _____
☐	☐	☐	☐	Case knows anyone else with similar symptoms
☐	☐	☐	☐	**Epidemiologic link to a confirmed case** *(only applies to Dengue; for Suspect case definition)* ☐ Travel to dengue endemic country ☐ Association in time and place with another case
☐	☐	☐	☐	Insect or tick bite ☐ Mosquito ☐ Tick ☐ Other: _____ ☐ Unknown insect or tick type Location of insect or tick exposure: _____ Date of exposure: ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
☐	☐	☐	☐	Blood transfusion or blood products (e.g. IG, factor concentrates) Date of receipt: ___/___/___
☐	☐	☐	☐	Organ or tissue transplant recipient Date of receipt: ___/___/___
☐	☐	☐	☐	Infant ☐ Birth mother had febrile illness ☐ Infected in utero ☐ Breast fed
☐	☐	☐	☐	Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____
☐	☐	☐	☐	Occupational exposure ☐ Lab worker ☐ Y ☐ N ☐ DK ☐ NA ☐ Other: _____

Where did exposure probably occur? ☐ In MT (County: _____) ☐ US but not MT ☐ Not in US ☐ Unk

Exposure details: _____

☐ **No risk factors or exposures could be identified**

☐ **Patient could not be interviewed**

PUBLIC HEALTH ISSUES

Y	N	DK	NA	
☐	☐	☐	☐	Neonatal Delivery location: _____
☐	☐	☐	☐	Pregnant Estimated delivery date ___/___/___ OB name, address, phone: _____
☐	☐	☐	☐	Did case donate blood products in the 30 days before symptom onset Date: ___/___/___ Agency and location: _____ Specify type of donation: _____
☐	☐	☐	☐	Did case donate organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___ Agency and location: _____ Specify type of donation: _____

PUBLIC HEALTH ACTIONS

☐ Breastfeeding education provided
☐ Notify blood or tissue bank
☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____