Arizona Department of Health Services

Arboviral Case Investigation Form

County/IHS ID number:

State ID Number

Patient's name

Clinical Picture:
- ☐ Uncomplicated Fever: must have 1 or more WNV-compatible symptoms
- ☐ Meningitis: must have lumbar puncture
- ☐ Encephalitis: must have physician diagnosis & altered mental status
- ☐ Asymptomatic
- ☐ Acute Flaccid Paralysis
- ☐ Other:

Patient hospitalized?
- ☐ Yes- Admit date:
- ☐ No

Is patient breastfeeding a child?
☐Yes ☐No

Is patient a breastfed child?
☐Yes ☐No

Past medical history:
- ☐ Cancer
- ☐ Diabetes: type:
- ☐ Viral Hepatitis
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Immunosuppressive Condition
- ☐ Pulmonary Disease
- ☐ Mosquito-borne illness: Dengue, Yellow fever, Japanese encephalitis, WNV, SLE, flavivirus

Symptoms (Check all that apply – circle primary symptom):
- ☐ Headache
- ☐ Fever (> 38ºC or 100ºF)

Max. temp. :
- ☐ Neck pain/stiffness
- ☐ Arthralgia or Myalgia
- ☐ Photophobia
- ☐ Rash
- ☐ Seizure
- ☐ Lymphadenopathy
- ☐ Tremors
- ☐ Extreme fatigue
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Shortness of breath
- ☐ Flaccid paralysis
- ☐ Spastic paralysis
- ☐ Profound muscle weakness
- ☐ Altered mental status
- ☐ Unconsciousness
- ☐ Other – specify:

Risk factor assessment:

Within 14 days of onset of symptoms, did the patient…

1) have known mosquito exposure? ☐Y ☐N
   Date(s): Location:
   Date(s): Location:

2) travel outside county of residence? ☐Y ☐N
   Date(s): Location:
   Date(s): Location:

3) travel outside Arizona? ☐Y ☐N
   Date(s): Location:
   Date(s): Location:

4) travel outside US? ☐Y ☐N
   Date(s): Location:
   Date(s): Location:

5) donate blood? ☐Y ☐N
   Date(s):

6) donate an organ or tissue? ☐Y ☐N
   Date(s):

In the 30 days prior to onset of symptoms, did the patient….

7) receive blood or blood product? ☐Y ☐N
8) receive an organ or tissue transplant? ☐Y ☐N

Vaccination history:
- ☐ Yellow fever Date:
- ☐ Japanese encephalitis Date:
- ☐ Tick-borne encephalitis Date:

Contact or person providing information, if other than patient:
Telephone: Relationship:

Acquired: ☐in utero ☐in a laboratory ☐occupationally (non-lab)

Length of Illness: days

Date of discharge, if hospitalized:

Outcome:
- ☐ Died Date:
- ☐ Full Recovery
- ☐ Recovery with sequelae (describe):

Treatment (check all that apply):
- ☐ Immunoglobulin
- ☐ Interferon
- ☐ Other Antiviral
- ☐ Supportive care only
- ☐ None

Case Classification:

Case acquisition:

Investigator:
Date initiated:
Date completed:

Attach this form to the case in MEDSIS