STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

WEST NILE VIRUS, CHIKUNGUNYA, AND OTHER HUMAN ARBOVIRUS INFECTIONS CASE REPORT FORM

Save Print Reset

PATIENT OR DONOR INFORMATION

PATIENT'S NAME (LAST, FIRST, MI)	WEBSURV CONDITION ID

PATIENT'S ADDRESS (NUMBER, STREET)	CITY

PATIENT'S TELEPHONE NUMBER(S)

MEDICAL CARE PROVIDER

PROVIDER'S NAME	TELEPHONE NUMBER

DEMOGRAPHICS

STATE OF RESIDENCE	COUNTY OF RESIDENCE	ZIP CODE

SEX	DATE OF BIRTH (MM/DD/YYYY)	RACE	HISPANIC ETHNICITY
☐ MALE ☐ FEMALE		☐ WHITE ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK ☐ PACIFIC ISLANDER ☐ REFUSED	☐ YES ☐ NO ☐ REFUSED

PREGNANT	OCCUPATION
☐ YES ☐ NO	

DIAGNOSTIC TESTING

SUBMITTER	LABORATORY

RESULT DATE	TEST	SPECIMEN DATE	QUALITATIVE RESULT			QUANTITATIVE RESULT
			POSITIVE	NEGATIVE	NOT DONE	
	SERUM ANTIBODY DETECTED IGM		☐	☐	☐	
	SERUM ANTIBODY TITER PRNT		☐	☐	☐	
	PAIRED ANTIBODY TITER PRNT		☐	☐	☐	
	CSF ANTIBODY DETECTED IGM		☐	☐	☐	
	CSF ANTIBODY TITER PRNT		☐	☐	☐	
	PCR OR NAT		☐	☐	☐	
	OTHER		☐	☐	☐	
	CSF PLEOCYTOSIS (≥5 WBC)		☐	☐	☐	

EPIDEMIOLOGIC INFORMATION

TRAVEL OUTSIDE OF THE UNITED STATES WITHIN 14 DAYS OF ONSET OF SYMPTOMS
☐ YES ☐ NO

FOREIGN TRAVEL DESTINATION 1	IF YES, COUNTRY	ARRIVAL	DEPARTURE
FOREIGN TRAVEL DESTINATION 2	IF YES, COUNTRY	ARRIVAL	DEPARTURE
FOREIGN TRAVEL DESTINATION 3	IF YES, COUNTRY	ARRIVAL	DEPARTURE

TRAVEL IN THE UNITED STATES ≤7 DAYS AFTER ILLNESS ONSET
☐ YES ☐ NO

DOMESTIC TRAVEL DESTINATION 1	IF YES, CITY AND STATE	ARRIVAL	DEPARTURE
DOMESTIC TRAVEL DESTINATION 2	IF YES, CITY AND STATE	ARRIVAL	DEPARTURE
DOMESTIC TRAVEL DESTINATION 3	IF YES, CITY AND STATE	ARRIVAL	DEPARTURE

EPIDEMIOLOGIC INFORMATION (CONTINUED)

OTHER DETAILS PERTINENT TO VIREMIC PHASE OF ILLNESS (UP TO 7 DAYS AFTER ILLNESS ONSET)

WERE BLOOD, BLOOD PRODUCTS, ORGANS, OR TISSUES RECEIVED OR DONATED WITHIN THE 14 DAYS PRIOR TO ONSET OF SYMPTOMS OR POSITIVE LABORATORY REPORT?
☐ YES ☐ NO

HAS THE TISSUE OR BLOOD BANK BEEN NOTIFIED OF THIS INFECTION?
☐ YES ☐ NO

NAME OF DONATION AGENCY

CONTACT NAME	CONTACT PHONE

IS THIS A CASE OF A

LABORATORY-ACQUIRED INFECTION?	☐ YES	☐ NO	☐ UNKNOWN
BREAST FED INFANT INFECTION?	☐ YES	☐ NO	☐ UNKNOWN
IN UTERO INFECTION?	☐ YES	☐ NO	☐ UNKNOWN

IF YES TO ANY OF THESE EXPOSURE ROUTES, DESCRIBE FOLLOW-UP OF OTHER POSSIBLE CONTACTS

CLINICAL HISTORY AND OUTCOME

DATE OF SYMPTOM(S) ONSET

☑ CHILLS/RIGORS	☐ DIARRHEA	☐ STIFF NECK	☐ OTHER MANIFESTATIONS (DESCRIBE BELOW)
☐ RASH	☐ MYALGIA	☐ ATAXIA	
☐ HEADACHE	☐ POLYARTHRALGIA	☐ PARKINSONISM/COGWHEEL RIGIDITY	
☐ FATIGUE/MALAISE	☐ POLYARTHRITIS	☐ ALTERED MENTAL STATUS	
☐ NAUSEA/VOMITING	☐ PARESIS OR PARALYSIS	☐ SEIZURES	

DID THE PATIENT HAVE A FEVER? ☐ YES _____ °C/F ☐ NO	IF NO, WAS PATIENT TAKING FEVER REDUCING MEDICATIONS? ☐ YES ☐ NO
HAS THE PATIENT USED A TREATMENT THAT SUPPRESSES THE IMMUNE SYSTEM? ☐ YES ☐ NO IF YES, LIST	DOES THE PATIENT HAVE AN IMMUNOSUPPRESSIVE CONDITION? ☐ YES ☐ NO IF YES, LIST
WAS THE PATIENT HOSPITALIZED BECAUSE OF THIS ILLNESS? ☐ YES ☐ NO IF YES, DATE HOSPITALIZED _____	DID THE PATIENT DIE DURING THIS ILLNESS? ☐ YES ☐ NO IF YES, DATE OF DEATH _____

FINAL CLASSIFICATION

☐ ASYMPTOMATIC INFECTION ☐ CONFIRMED ☐ PROBABLE ☐ INDETERMINATE ☐ NO CASE

VECTOR CONTROL AGENCY HAS BEEN ADVISED OF RISK OF LOCAL ARBOVIRUS TRANSMISSION
☐ YES ☐ NO ☐ NOT NEEDED

LOCAL INVESTIGATOR WHO COMPLETED THIS REPORT	DATE
DHSS DISTRICT STAFF REVIEWER	DATE