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 from 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		□ Pos □ Neg		___/___/___	□ Pos □ Neg		___/___/___
IFA IgM		□ Pos □ Neg		___/___/___	□ Pos □ Neg		___/___/___
EIA/ELISA IgG		□ Pos □ Neg		___/___/___	□ Pos □ Neg		___/___/___
EIA/ELISA IgM		□ Pos □ Neg		___/___/___	□ Pos □ Neg		___/___/___

CSF: □ Pos □ Neg (Collected: ___/___/___) **PCR:** □ Pos □ Neg (Collected: ___/___/___) **PRNT:** □ Pos □ Neg (Collected: ___/___/___)

INVESTIGATION SUMMARY

INVESTIGATION

***Disease:** □ Dengue Fever □ Dengue Hemor. Fever □ Chikungunya □ Zika □ West Nile Neuro. □ West Nile Non-Neuro. □ La Crosse □ St. Louis Encephalitis □ Other _____
***Jurisdiction:** _____
Investigation Start Date: ____/____/____
***Investigation Status:** □ Open □ Closed
Investigator: _____

HOSPITAL

Physician: _____
Was the patient hospitalized for this illness? □ Yes □ No □ Unknown
If yes, Hospital: _____
Diagnosis Date: ____/____/____
***Illness Onset Date:** ____/____/____ **Illness End Date:** ____/____/____
Is the patient pregnant? □ Yes □ No □ Unknown
Did the patient die from this illness?
□ Yes (Date of death: ____/____/____) □ No □ Unknown

CLINICAL INFORMATION

SYMPTOMS

□ Aphasia □ Behavioral Changes □ Confusion □ Cough □ Diarrhea □ Epistaxis □ Eye pain □ Fever (max. temp.: _____) □ Fever lasting 2 - 7 days
□ Headache □ Hematuria □ Intracranial Calcification □ Jaundice □ Joint Pain □ Leukopenia □ Loss of consciousness □ Microcephaly □ Muscle aches □ Nausea
□ Photophobia □ Plasma leakage □ Profound Weakness □ Purpura/Echymosis □ Rash □ Seizures □ Sore Throat □ Stiff Neck □ Thrombocytopenia □ Vomiting

OTHER

Sources of Infection (select all that apply — Y=Yes, N=No, U=Unknown):

Y	N	U		Y	N	U	
□	□	□	Occupationally Lab Acquired	□	□	□	Non-Occupationally Lab Acquired
□	□	□	*Blood Transfusion Received	□	□	□	Blood Donor
□	□	□	*Identified by Blood Donor Screening	Date of Blood Donation: ____/____/____			
□	□	□	*Organ Donor	□	□	□	*Organ Transplant Received
□	□	□	*Breastfed Infant	□	□	□	*Infected in Utero

Did the patient travel outside home county in the two weeks before symptom onset?
□ Yes (Where/Date: _____) □ No
Was the patient part of a Group Trip?
□ Yes (What group: _____) □ No
Group Coordinator (Name/phone:_____)
Any known ill Contacts (Name/phone:_____)

***Clinical Syndrome (must choose one)**
— See 'Arboviral Clinical Syndrome Guidelines' for details. —

Neuroinvasive Clinical Syndromes:
□ Acute Flaccid Paralysis (AFP) without Encephalitis or Meningitis†
□ Encephalitis—Including Meningoencephalitis (with or without AFP)
□ Meningitis (with or without AFP)
† If patient has AFP without encephalitis or meningitis, choose 'Other Clinical' as the clinical syndrome in NBS.

Non-Neuroinvasive Clinical Syndromes:
□ Asymptomatic (for tissue and blood donors with no symptoms)
□ Hepatitis/Jaundice
□ Multi organ failure
□ Other Clinical
□ Uncomplicated fever (fever without neuro. involvement)
□ Unknown

Dengue Clinical Syndromes:
□ Asymptomatic
□ Dengue Fever
□ Dengue with Hemorrhage
□ Dengue Hemorrhagic Fever/Dengue Shock Syndrome
□ Uncomplicated fever (fever without criteria for above dengue syn.)
□ Unknown

*CASE STATUS (SEE CASE DEFINITION FOR DETAILS)

□ **Confirmed** □ **Suspect**
□ **Probable** □ **Not a Case**