FLORIDA CONFIDENTIAL VECTOR-BORNE DISEASE INFECTION CASE REPORT

(To be completed for all laboratory presumptive and confirmed cases)

☐St. Louis Encephalitis ☐Eastern Equine Encephalitis ☐West Nile virus ☐Dengue
☐LaCrosse/CA Encephalitis ☐Venezuelan Equine Encephalitis ☐Western Equine Encephalitis ☐Yellow Fever
☐Other_____ **Check one**: ☐Neuroinvasive ☐Non-neuroinvasive

IDENTIFYING DATA: County:_____ Merlin Case #:_____

Name: _____ Date of Birth: ___/___/___ Gender: ☐Male ☐Female
Last First MI mm dd yyyy

Home Address: _____
Street City State Zip

Home Phone: (_____)_____ Employer/School: _____
Name Address Zip

Race/Ethnicity: ☐White ☐Black ☐Hispanic ☐American Indian/Alaska Native ☐Asian/Pacific Islander ☐Unknown/Not specified

Homeless: ☐Yes ☐No

Hospitalized: ☐ Yes ☐ No
If yes, Hospital: _____ Physician:_____ Physician Phone:(____)_____
Date of Admission:___/___/_____ Discharge or death:___/___/_____

CLINICAL SYMPTOMS: Date of Illness Onset (**Required Field**) (mm/dd/yyyy):_____/_____/_____

	YES	NO	UNK		YES	NO	UNK		YES	NO	UNK
Fever ≥100F	☐	☐	☐	Disorientation	☐	☐	☐	Diarrhea	☐	☐	☐
Highest Temp. _____ºF				Thrombocytopenia	☐	☐	☐	Seizures	☐	☐	☐
Headache	☐	☐	☐	Nausea	☐	☐	☐	Stiff Neck	☐	☐	☐
Myalgia	☐	☐	☐	Confusion	☐	☐	☐	Paralysis	☐	☐	☐
Arthralgia	☐	☐	☐	Coma	☐	☐	☐	Muscle Weakness	☐	☐	☐
Rash	☐	☐	☐	Chills	☐	☐	☐	Hemorrhage	☐	☐	☐
Vomiting	☐	☐	☐	Retroorbital pain	☐	☐	☐	Decrease Consciousness	☐	☐	☐
Leukopenia	☐	☐	☐	Other_____							

Outcome: ☐Survived ☐Died ☐Unknown Date of death (mm/dd/yyyy)_____/_____/_____
Date of Last follow-up _____/_____/_____

LABORATORY DATA:

Acute specimens must be collected within 5 days of onset of symptoms. Convalescent specimens should be collected 10 days to 4 weeks later.

Serum or CSF (specify acute or convalescent)	Date Collected (mm/dd/yyyy)	Laboratory Name	Test Type	Lab Report Date (mm/dd/yyyy)	Results

∗ **Bureau of Public Health Laboratories – Tampa or Jacksonville Branch results are required for confirmation**

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Merlin Case #_____County:_____ Pt's initials:____

RISK FACTOR INFORMATION:

1. Does the patient's residence have screened windows? ☐ Yes ☐ No ☐ Unknown
2. During the two weeks before onset of illness does the patient recall being bitten by mosquitoes?
   ☐ Yes ☐ No If yes, dates and places _____
3. Is the patient a smoker? ☐ Yes ☐ No ☐ Unknown
   If yes, do they smoke outdoors? ☐ Yes ☐ No ☐ Unknown
4. Has the patient spent extended time outdoors in the two weeks prior to onset? ☐ Yes ☐ No ☐ Unknown
5. Does the patient use any prevention measures to avoid mosquito bites (Drain and Cover)? ☐ Yes ☐ No ☐ Unknown
   If yes, list_____
   Does the patient use mosquito repellent when outdoors: ☐Always ☐Sometimes ☐Rarely ☐Never
   Does the repellent contain DEET (N, N-diethyl-meta-toluamide, or N, Ndiethyl-3-methylbenzamide)
   ☐Yes ☐No ☐Unknown
6. During the two weeks before onset did the patient travel outside the county of residence?
   ☐Yes ☐No ☐Unk If yes, specify when and where: _____
7. Has the patient traveled outside of Florida in the two weeks prior to onset? ☐ Yes ☐ No ☐ Unknown
   If yes, specify when and where: _____
8. Has the patient traveled outside the U.S. in the two weeks prior to onset? ☐ Yes ☐ No ☐ Unknown
   If yes, specify when and where: _____
9. Has any other household member experienced a febrile illness within the month prior to or the month after onset?
   ☐ Yes ☐ No ☐ Unknown
10. Does the patient have any underlying medical conditions? ☐ Yes ☐ No ☐ Unknown
    If yes, specify _____
11. What is the patient's occupation?_____

FOR FEVER CASES (NON-NEUROINVASIVE) PATIENTS:

12. Has anyone in the household or close personal contact travelled to a dengue endemic country in the month prior to onset of symptoms? ☐ Yes ☐ No ☐ Unknown
13. Has the patient ever traveled or lived in a dengue endemic country? ☐ Yes ☐ No ☐ Unknown
    If yes, what country _____ When _____
14. Has the patient ever been previously diagnosed with dengue? ☐ Yes ☐ No ☐ Unknown
    If yes, year_____ Country of origin _____
    serotype: ☐ DENV-1 ☐ DENV-2 ☐ DENV-3 ☐ DENV-4

BLOOD DONATION/TRANSFUSION/TRANSPLANT HISTORY/PREGNANCY:

15. Has the patient received transplant or blood product transfusions in the month prior to onset? ☐ Yes ☐No ☐ Unknown
    If yes, specify when and where: _____
16. Has patient donated blood products in the one month prior to onset? ☐ Yes ☐ No ☐ Unknown
    If yes, specify when and where: _____
17. Is the patient currently pregnant? ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
    If yes, weeks pregnant_____ due date ___/___/_____
18. Is the patient breastfeeding or planning to breastfeed? ☐ Yes ☐ No ☐ Unknown

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VACCINE INFORMATION

19. Has patient received yellow fever (YF) vaccine? ☐Yes (date:__/__/__) ☐No ☐Unknown

20. Has patient received Japanese encephalitis (JE) vaccine? ☐Yes (date:__/__/__) ☐No ☐Unknown

21. Has patient received Central European encephalitis (CEE) vaccine? ☐Yes (date:__/__/__) ☐No ☐Unknown

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MEDICAL HISTORY *(WEST NILE VIRUS INFECTIONS ONLY)

22. Before the patient was diagnosed with West Nile virus infection, did he/she have any of the following medical conditions?

Diabetes	☐ Yes	☐ No	☐ Unk	Kidney failure or chronic kidney disease	☐ Yes	☐ No	☐ Unk
High blood pressure	☐ Yes	☐ No	☐ Unk	Angina or coronary artery disease	☐ Yes	☐ No	☐ Unk
Heart attack	☐ Yes	☐ No	☐ Unk	Congestive heart failure	☐ Yes	☐ No	☐ Unk
Stroke	☐ Yes	☐ No	☐ Unk	Chronic obstructive pulmonary disease	☐ Yes	☐ No	☐ Unk
Chronic liver disease	☐ Yes	☐ No	☐ Unk	Kidney failure or chronic kidney disease	☐ Yes	☐ No	☐ Unk
Alcoholism	☐ Yes	☐ No	☐ Unk	Bone marrow transplant	☐ Yes	☐ No	☐ Unk

Herpes Simplex Virus (HSV)	☐ Yes	☐ No	☐ Unk	Epstein - Barr virus (EBV)	☐ Yes	☐ No	☐ Unk
Influenza	☐ Yes	☐ No	☐ Unk	Streptococcus	☐ Yes	☐ No	☐ Unk

Other current or chronic viral or bacterial infection ☐ Yes ☐ No ☐ Unk if yes, what? _____

Solid organ transplant ☐ Yes ☐ No ☐ Unknown
If yes: What organ was transplanted?: _____
What year was the transplant?: _____

Cancer ☐ Yes ☐ No ☐ Unknown
If yes: What type(s)?: _____
What year were you diagnosed?: _____
Are you currently being treated for cancer?: ☐ Yes ☐ No ☐ Unknown

23. Before the patient was diagnosed with West Nile virus infection, did he/she have a medical condition that limited the ability to fight an infection? ☐ Yes ☐ No ☐ Unknown
If yes: What condition(s)?: _____

24. At the time of diagnosis with West Nile virus infection, was the patient taking any of the following types of prescription medications or treatments?

Acyclovir	☐ Yes	☐ No	☐ Unknown
Chemotherapy	☐ Yes	☐ No	☐ Unknown
Other treatments for cancer	☐ Yes	☐ No	☐ Unknown
Hemodialysis	☐ Yes	☐ No	☐ Unknown
Other treatments for kidney disease	☐ Yes	☐ No	☐ Unknown
Oral or injected steroids (not inhaled or topical)	☐ Yes	☐ No	☐ Unknown
Insulin or other medications to treat diabetes	☐ Yes	☐ No	☐ Unknown
Medications to treat high blood pressure	☐ Yes	☐ No	☐ Unknown
Medications to treat coronary artery disease	☐ Yes	☐ No	☐ Unknown
Medications to treat congestive heart failure	☐ Yes	☐ No	☐ Unknown
Medications that suppress the immune system	☐ Yes	☐ No	☐ Unknown

25. Which of the following sources provided the information above? **(check all that apply)**

Patient	☐ Yes	☐ No	Family member/friend	☐ Yes	☐ No
Provider	☐ Yes	☐ No	Medical record	☐ Yes	☐ No

COMMENTS: _____

_____

_____

Date _____ Investigator _____ Phone (____) _____
(Please print)

Please submit form to the Division of Disease Control and Health Protection, Dept. of Health by uploading electronically into Merlin.