Today's date: Day_____/Month_____/Year_____

Check suspected arboviral infection (Check all that apply): ☐ Dengue ☐ Zika ☐ Chikungunya ☐ Other _____

ARBOVIRUS CASE INVESTIGATION FORM

Puerto Rico Public Health Laboratory, Department of Health
Building A – Second Floor, Medical Center Area
P.O. Box 70184, San Juan, PR 00926
Tel. (787)765-2929 ext. 3728, Fax (787) 274-5710

GOBIERNO DE PUERTO RICO
Departamento de Salud

Please read and complete ALL sections. See instructions on back page.

1. Patient Data

Hospitalized due to this illness: No ☐ Yes ☐ → Hospital Name: Record Number:

Name of Patient: _____
Last Name First Name Middle Name or Initial

If patient is a minor, name of father or primary caregiver: _____
Last Name First Name Middle Name or Initial

Fatal: Yes ☐ No ☐ Unk ☐

Mental status changes: Yes ☐ No ☐ Unk ☐

2. Patient's Home (Physical) Address

Home address here

Housing Development/Building:

Number: Street:

City: Zip code: __ __ __ __ __ - __ __ __ __

Tel: Other Tel:

Residence is close to:

Work address:

3. Patient's Demographic Information

Date of Birth: _____/_____/_____ (Day / Month / Year)

Age: _____month or _____years

Sex: M ☐ F ☐

Pregnant: Y ☐ N ☐ UNK ☐

Weeks pregnant (gestation): ☐

Estimated Date of Delivery: Day_____/Month_____/Year_____

4. Patient Symptom Status and Onset/Date of Specimen

Patient symptomatic? ☐ Yes ☐ No

If symptomatic, date of first symptom(s): Day _____/Month _____/Year _____

Date specimen taken:

Serum sample _____/_____/_____

Other sample (Specify type:_____) _____/_____/_____

Other sample (Specify type:_____) _____/_____/_____

Other sample (Specify type:_____) _____/_____/_____

5. Physician contact information

Physician who ordered test - Name:

National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

Tel: Fax: Email:

Mailing address: Number: Street:

City: Zip code:___ ___ ___ ___ ___ - ___ ___ ___ ___

Hospital/Clinic/Laboratory: Specialty:

Primary care doctor- Name:

National Provider Idenifier (NPI): ☐☐☐☐☐☐☐☐☐☐

Tel: Fax: Email:

Mailing address: Number: Street:

City: Zip code: ___ ___ ___ ___ ___ - ___ ___ ___ ___

Hospital/Clinic/Laboratory: Specialty:

6. Who filled out this form?

Name: Relationship with patient:

Tel: Fax: Email:

7. Additional Patient Data

Country of birth: _____

During the 14 days before onset of illness, did you TRAVEL to other municipalities, or countries?

☐ Yes, another country ☐ Yes. another municipality ☐ No ☐ Unknown

Where did you Travel? _____

8. Description of patient's signs and symptoms experienced at time of form completion

	Yes	No	Unk
Fever lasting 2-7 days	☐	☐	☐
Fever now(>38°C)	☐	☐	☐
Platelets ≤100,000/mm³	☐	☐	☐
Platelet count: _____			
Any hemorrhagic manifestation			
Petechiae	☐	☐	☐
Purpura/Ecchymosis	☐	☐	☐
Vomit with blood	☐	☐	☐
Blood in stool	☐	☐	☐
Nasal bleeding	☐	☐	☐
Bleeding gums	☐	☐	☐
Blood in urine	☐	☐	☐
Vaginal bleeding	☐	☐	☐
Positive urinalysis (over 5 RBC/hpf or positive for blood)	☐	☐	☐
Tourniquet test ☐ Pos ☐ Neg ☐ Not done			

Symptoms	Yes	No	Unk
Rapid, weak pulse	☐	☐	☐
Pallor or cool skin	☐	☐	☐
Chills	☐	☐	☐
Rash	☐	☐	☐
Headache	☐	☐	☐
Eye pain	☐	☐	☐
Body (muscle/bone) pain	☐	☐	☐
Joint pain	☐	☐	☐
Anorexia	☐	☐	☐
Encephalitis/Meningitis	☐	☐	☐
Infant (only)			
Microcephaly	☐	☐	☐
Intracranaial calcifications	☐	☐	☐
Other birth defect(s)	☐	☐	☐
Specify _____			
Mother with positive or indeterminate Zika test results	☐	☐	☐

Warning signs	Yes	No	Unk
Persistent vomiting	☐	☐	☐
Abdominal pain/Tenderness	☐	☐	☐
Mucosal bleeding	☐	☐	☐
Lethargy, restlessness	☐	☐	☐
Liver enlargement >2cm	☐	☐	☐
Pleural or abdominal effusion	☐	☐	☐
Additional symptoms			
Diarrhea	☐	☐	☐
Cough	☐	☐	☐
Conjunctivitis	☐	☐	☐
Nasal congestion	☐	☐	☐
Sore throat	☐	☐	☐
Jaundice	☐	☐	☐
Convulsion or coma	☐	☐	☐
Nausea and vomiting (occasional)	☐	☐	☐
Arthritis (Swollen joints)	☐	☐	☐

9. For laboratory use

Case number ☐☐☐☐☐☐

SAN ID ☐☐☐☐☐☐ GCODE ☐☐

Specimen #	Days post onset (DPO)	Type	Date Received
S1			_____/_____/_____
S2			_____/_____/_____
S3			_____/_____/_____
S4			_____/_____/_____