**Department of Health Services**
Division of Public Health

**CDES # 103 (07/10)**

# Wisconsin Arbovirus Infection Follow-up Form

## Patient / Physician Information

Patient's Name: _____ Patient Phone : _____

Street Address: _____ County of Residence: _____

City: State: Zip Code:

Agency Reporting (name and address): _____

Physician (name and address): _____ Physician Phone: _____

LHD Reporting: Date reported to HD: ___/____/_____ Date Rec'd at LHD: ___/____/_____

Sex: ☐ Male ☐ Female ☐ Unknown Date of birth: ____/____/_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Unknown

Was the patient pregnant? ☐ Yes ☐ No ☐ Unk

Patient hospitalized? ☐ Yes ☐ No ☐ Unk Admission date: ___/____/_____

Hospital:_____ Discharge date : ___/____/_____

Patient died from this illness? ☐ Yes ___/____/_____ ☐ No ☐ Unk

## Arbovirus Infection

| | | |
|---|---|---|
| ☐ West Nile virus | ☐ La Crosse | ☐ Dengue |
| ☐ Eastern Equine Encephalitis (EEE) | ☐ Western Equine Encephalitis | ☐ St. Louis Encephalitis |
| ☐ Chikungunya | ☐ Powassan | ☐ Other: _____ |

## Laboratory Testing

| | Collection Date | Specimen Source (e.g. serum, CSF) | Test Method (e.g. PCR, EIA) | Arbovirus test (agent/antibody) | Results (positive, negative, or equivocal and index/titer) |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |

**Laboratory performing test:** ☐ WSLH ☐ CDC ☐ Commercial Laboratory (please specify) _____

(Note: IgM+ results from commercial labs must be verified at the WSLH or CDC. A positive IgG and negative IgM usually indicates past infection.)

## Clinical Information

***Signs and Symptoms***: **Date of Onset**: ___/____/_____ ☐ **Asymptomatic**

☐ **Fever** ☐ **Chills** ☐ **Rash** ☐ **Headache** ☐ **Photophobia** ☐ **Fatigue/Weakness** ☐ **Muscle Aches**
☐ **Joint Pain** ☐ **Stiff Neck** ☐ **Nausea** ☐ **Vomiting** ☐ **Diarrhea** ☐ **Disorientation** ☐ **Memory deficit**
☐ **Confusion** ☐ **Slurred speech** ☐ **Coma** ☐ **Tremors** ☐ **Convulsions** ☐ **Seizures** ☐ **Gait/balance difficulty**
☐ **Other (please specify) :** _____

**Was meningitis, encephalitis, or acute flaccid paralysis (AFP) documented?** ☐ **Meningitis** ☐ **Encephalitis** ☐ **AFP**

**If DENGUE, did the patient have any of the following during their illness?** **Previous history of dengue:** ***year*** _____

☐ **Petichiae** ☐ **Purpura/Ecchymosis** ☐ **Vomit with blood** ☐ **Blood in stool** ☐ **Nasal bleeding**
☐ **Bleeding in gums** ☐ **Blood in urine** ☐ **Vaginal bleeding** ☐ **Pleural or abdominal effusion** ☐ **Eye pain**
☐ **Conjunctivitis** ☐ **Body pain** ☐ **Pallor or cool skin** ☐ **Jaundice** ☐ **Plasma leakage**
☐ **Thrombocytopenia** ☐ **Rapid, weak pulse** ☐ **Narrow pulse pressure**
☐ **Other (please specify) :** _____

## Risk of Exposure

1. **During the 30 days prior to the onset of illness, did the patient do any of the following:**
   ☐ Receive blood or blood products (transfusion) Date of transfusion___/___/_____
   ☐ Receive organ transplant Date of transplant___/___/_____

2. **During the 14 days prior to the onset of illness did the patient travel (excluding normal travel)?** ☐ Yes ☐ No ☐ Unknown
   If yes: Start date: ___/____/_____ End date ___/___/_____ Location:_____

3. **Did the patient have a known history of mosquito exposure and/or bites within the 14 days prior to the onset of illness?**
   ☐ Yes, bites ☐ Yes, exposure only ☐ No exposure ☐ Unknown

4. **Did the patient have a known history of tick exposure and/or bites within the 14 days prior to the onset of illness?**
   ☐ Yes, bites ☐ Yes, exposure only ☐ No exposure ☐ Unknown

5. **Does the patient use mosquito/tick repellent that contains DEET when outdoors for more than 30 minutes:**
   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Never

6. **During the 30 days prior to the onset of illness, did the patient do any of the following:**
   ☐ Donate blood or blood products Date___/___/_____ Identified by donor screening: ☐ Yes ☐ No ☐ Unknown
   ☐ Donate organs Date___/___/_____
   Agency and contact information: _____

**If WEST NILE VIRUS**

7. **Was the patient infected in utero?** ☐ Yes ☐ No ☐ Unknown

8. **Was the patient breastfeeding at the time of symptom onset?** ☐ Yes ☐ No ☐ Unknown