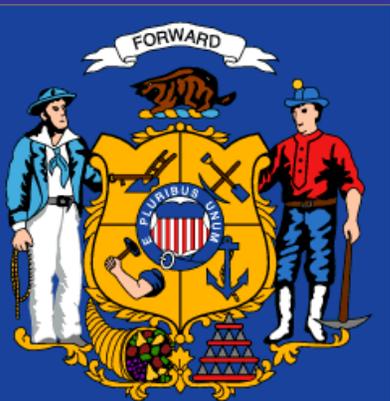


WEDSS Reporting – Vectorborne Diseases, WI, 2010

Diep (Zip) Hoang Johnson
Wisconsin Division of Public Health
608-267-9000
07/09/10



Ehrlichia/Anaplasma- What is needed in WEDSS

DISEASE INCIDENT		Patient		Supplemental		A/E LabClinical		A/E Risk		Case Investigation	
Patient: TEST,BOB		Disease Incident ID: 370081				Process Status: New					
DOB:		Disease: EHRlichiosis/ANAPLAsmosis, A. phagocytophilum				Resolution Status: Suspect					
RICKETTSIAL - CLINICAL SIGNS & SYMPTOMS		Clinically Compatible Illness Present (if no, STOP)		Yes		Date of Onset of Symptoms		6/14/2010			
Underlying Immunosuppressive Condition Present		No		Condition - Specify							
Life Threatening Complications In Clinical Course Of Illness		Adult Respiratory Distress Syndrome (ARDS)		No		Disseminated Intravascular coagulopathy (DIC)		No			
Was Meningitis Or Encephalitis Documented		Neither		Renal Failure		No					
Other (Y/N/U)				Other Life-Threatening Complications							
RICKETTSIAL - CLINICAL OUTCOMES		Hospitalized for this illness		Yes		Date of Hospitalization		6/16/2010			
Date of Discharge		6/17/2010		Did patient die of this illness?		No					
Date of Death											

Lab Section

Patient

Supplemental

A/E LabClinical

A/E Risk

Case Investigation

Anaplasmosis/Ehrlichiosis laboratory data

ALL POSITIVE AND NEGATIVE IgM/IgG TITERS SHOULD BE REPORTED FOR EACH ANAPLASMA (A) AND EHRLICHIA (E) SPECIES. IF TESTING WAS NOT DONE FOR A CERTAIN SPECIES, PLEASE INDICATE.

Serologic Tests

Serology #1 Sample Collection Date	6/15/2010	Serology #1 IFA-IgG Titer____1:	HA 1:64; E not tested
Serology #1 IFA-IgG Titer Interpretation	Positive	Serology #1 IFA-IgM Titer____1:	
Serology #1 IFA-IgM Titer Interpretation		Other Test #1	
Other Test #1 Results		Serology #2 Sample Collection Date	
Serology #2 IFA-IgG Titer____1:		Serology #2 IFA-IgG Titer Interpretation	
Serology #2 IFA-IgM Titer____1:		Serology #2 IFA-IgM Titer Interpretation	
Other Test #2		Other Test #2 Results	
Fourfold Rise in Antibody Titer Between Specimens			

RICKETTSIAL - LABORATORY DATA

Laboratory Name	Marshfield Laboratories	Laboratory Address	1000 N Oak Ave., Marshfield, WI
PCR Positive		Morulae Visualization	
Immunostain Positive		Culture	

Ehrlichiosis - Classification as assigned by WI DPH

Case Classification	Probable
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PCR

Patient	Supplemental	A/E LabClinical	A/E Risk	Case Investigation
Serologic Tests				
Serology #1 Sample Collection Date	6/16/2010		Serology #1 IFA-IgG Titer___1:	
Serology #1 IFA-IgG Titer Interpretation			Serology #1 IFA-IgM Titer___1:	
Serology #1 IFA-IgM Titer Interpretation			Other Test #1	PCR + E. chaffeensis
Other Test #1 Results			Serology #2 Sample Collection Date	
Serology #2 IFA-IgG Titer___1:			Serology #2 IFA-IgG Titer Interpretation	
Serology #2 IFA-IgM Titer___1:			Serology #2 IFA-IgM Titer Interpretation	
Other Test #2			Other Test #2 Results	
Fourfold Rise in Antibody Titer Between Specimens				
RICKETTSIAL - LABORATORY DATA				
Laboratory Name	Mayo Clinic	Laboratory Address	200 1st st SW, rochester, MN	
PCR Positive	Yes	Morulae Visualization		
Immunostain Positive		Culture		

Risk Tab

Patient	Supplemental	A/E LabClinical	A/E Risk	Case Investigation
Anaplasmosis/Ehrlichiosis travel history				
Indicate below patient's travel out of Wisconsin within 30 days prior to onset.				
Out of Wisconsin travel		<input type="radio"/> Yes	<input checked="" type="radio"/> No	
		<input type="radio"/> Unk		
State	<input type="text"/>	Non-Wisconsin county	<input type="text"/>	
Indicate below patient's travel out of county of residence within 30 days prior to onset.				
Out of county travel		<input type="radio"/> Yes	<input checked="" type="radio"/> No	
		<input type="radio"/> Unk	County	<input type="text"/>
				<input type="button" value="BACK"/> <input type="button" value="NEXT"/> <input type="button" value="CANCEL"/> <input type="button" value="PRINT TAB"/>

Lyme - What is needed in WEDSS Lab Clinical Tab

Patient	Supplemental	Lyme-LabClinical	Lyme-Risk	Lyme-Intervntn	Case Investigation
Lyme - Laboratory Findings					
<p>Laboratory evidence of Lyme disease: A qualified laboratory assay is (1) a positive culture for <i>B. burgdorferi</i>, (2) two-tier testing* with IgM immunoblot seropositive result for specimens collected within 30 days of onset date, or (3) positive IgG immunoblot interpreted using established criteria. Additional assays including PCR will be considered on a case by case basis.</p> <p>*Two tier testing includes an initial screen by enzyme immunosorbent assay (EIA) or indirect immunofluorescence assay (IFA), followed by a Western immunoblot on any equivocal or positive EIA or IFA results.</p> <p>.....</p>					
Lyme EIA/IFA		<input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Total	Lyme EIA/IFA collection date	<input type="text" value="4/21/2010"/>	
If specimen was not serum, specify	<input type="text"/>	Lyme EIA/IFA result	<input checked="" type="radio"/> Pos <input type="radio"/> Equivocal	<input type="radio"/> Neg <input type="radio"/> Not done	

Lab/Clinical Continued

Lyme Western Blot (WB)
collection date

4/21/2010



If not serum, specify

Lyme WB IgM

- Pos Neg
 Equivocal Not done

Indicate positive WB IgM bands, if known. 2 of 3 bands must be positive

- 41 kDa (FlaB) 39 kDa (BmpA)
 21-25 kDa (OspC)

Lyme WB IgG

- Pos Neg
 Equivocal Not done

Indicate positive WB IgG bands, if known. 5 of 10 bands must be positive

- 93 kDa 66 kDa
 58 kDa 45 kDa
 41 kDa 39 kDa
 30 kDa 28 kDa
 21 - 25 kDa (OspC) 18 kDa

Other tests (check all that apply)

B. burgdorferi cultured

Other lyme tests

CSF titer higher than serum titer

Specify additional assay

ANA negative

Additional assays (including PCR)

Signs and Symptoms- Confirmed

Patient	Supplemental	Lyme-LabClinical	Lyme-Risk	Lyme-Intervntn	Case Investigation
Lyme - Clinical signs and symptoms					
Did a physician diagnose patient w/ Lyme disease?		<input checked="" type="radio"/> Yes	<input type="radio"/> No	Symptom onset date	4/19/2010
LYME CONFIRMATORY SIGNS AND SYMPTOMS					
EM rash (> 5 cm in diameter)	<input type="radio"/> Yes	<input checked="" type="radio"/> No	Arthritis (objective episodes of joint swelling)	<input checked="" type="radio"/> Yes	<input type="radio"/> No
	<input type="radio"/> Unk			<input type="radio"/> Unk	
Bells palsy or other cranial neuritis	<input type="radio"/> Yes	<input checked="" type="radio"/> No	Encephalomyelitis*	<input type="radio"/> Yes	<input checked="" type="radio"/> No
	<input type="radio"/> Unk			<input type="radio"/> Unk	
Lymphocytic meningitis	<input type="radio"/> Yes	<input checked="" type="radio"/> No	Radiculoneuropathy	<input type="radio"/> Yes	<input checked="" type="radio"/> No
	<input type="radio"/> Unk			<input type="radio"/> Unk	
2nd or 3rd degree atrioventricular block	<input type="radio"/> Yes	<input checked="" type="radio"/> No			
	<input type="radio"/> Unk				
*If encephalomyelitis is checked "Yes", CSF titer must be higher than serum titer.					
LYME NON-CONFIRMATORY SIGNS AND SYMPTOMS--check all that apply.					
<input checked="" type="checkbox"/> Arthralgias					<input type="checkbox"/> Bundle branch block
<input type="checkbox"/> Cognitive impairment					<input type="checkbox"/> Encephalopathy.
<input type="checkbox"/> Fatigue.					<input type="checkbox"/> Fever/Sweats/Chills
<input type="checkbox"/> Headache					<input type="checkbox"/> Myalgias (muscle aches)
<input type="checkbox"/> Myocarditis					<input type="checkbox"/> Neck pain
<input type="checkbox"/> Other rash					<input type="checkbox"/> Palpitations
<input type="checkbox"/> Paresthesias					<input type="checkbox"/> Peripheral neuropathy
<input type="checkbox"/> Visual/auditory impairment					
Symptom(s) not listed above	<input type="text"/>				

Signs and Symptoms- Probable

Patient	Supplemental	Lyme-LabClinical	Lyme-Risk	Lyme-Intervntn	Case Investigation
Lyme - Clinical signs and symptoms					
Did a physician diagnose patient w/ Lyme disease?		<input checked="" type="radio"/> Yes	<input type="radio"/> No	Symptom onset date	5/26/2010
LYME CONFIRMATORY SIGNS AND SYMPTOMS					
EM rash (> 5 cm in diameter)	<input type="radio"/> Yes <input type="radio"/> Unk	<input checked="" type="radio"/> No	Arthritis (objective episodes of joint swelling)	<input type="radio"/> Yes <input type="radio"/> Unk	<input checked="" type="radio"/> No
Bells palsy or other cranial neuritis	<input type="radio"/> Yes <input type="radio"/> Unk	<input checked="" type="radio"/> No	Encephalomyelitis*	<input type="radio"/> Yes <input type="radio"/> Unk	<input checked="" type="radio"/> No
Lymphocytic meningitis	<input type="radio"/> Yes <input type="radio"/> Unk	<input checked="" type="radio"/> No	Radiculoneuropathy	<input type="radio"/> Yes <input type="radio"/> Unk	<input checked="" type="radio"/> No
2nd or 3rd degree atrioventricular block	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No			
*If encephalomyelitis is checked "Yes", CSF titer must be higher than serum titer.					
LYME NON-CONFIRMATORY SIGNS AND SYMPTOMS--check all that apply.					
<input checked="" type="checkbox"/> Arthralgias	<input type="checkbox"/> Cognitive impairment	<input type="checkbox"/> Myocarditis	<input type="checkbox"/> Other rash	<input type="checkbox"/> Paresthesias	<input type="checkbox"/> Visual/auditory impairment
<input type="checkbox"/> Bundle branch block	<input type="checkbox"/> Encephalopathy.	<input checked="" type="checkbox"/> Fever/Sweats/Chills	<input checked="" type="checkbox"/> Myalgias (muscle aches)	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Peripheral neuropathy					
Symptom(s) not listed above					

Clinician Information

Patient	Supplemental	Lyme-LabClinical	Lyme-Risk	Lyme-Intervntn	Case Investigation
Clinician information					
Physician/medical provider name	Anne Eglash	Clinic Name	UW Health Mt Horeb		
Address		Phone number			

Lyme – Risk Tab

Patient	Supplemental	Lyme-LabClinical	Lyme-Risk	Lyme-Intervntn	Case Investigation
Lyme - Exposure					
Potential tick habitats: wooded, brushy, or grassy areas in a county in which Lyme disease is endemic (e.g. any county in Wisconsin).					
Exposure: if EM is present, was the patient in potential tick habitats in a Lyme disease endemic county <= 30 days before onset?					
Tick habitats <= 30 days before onset?		<input checked="" type="radio"/> Yes	<input type="radio"/> No		
		<input type="radio"/> Unk			
County	dane		State	wi	
If the patient had EM, was there:	<input type="radio"/> A single EM	<input type="radio"/> Multiple EM rashes			

Lyme – Intervention Tab

Patient	Supplemental	Lyme-LabClinical	Lyme-Risk	Lyme-Intervntn	Case Investigation
Lyme - Treatment					
Antibiotics used for this illness (check all that apply)					
<input checked="" type="checkbox"/> Doxycycline	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Azithromycin	<input type="checkbox"/> Other (not listed above)	<input type="checkbox"/> Ceftriaxone	<input type="checkbox"/> Amoxicillin
<input type="checkbox"/> Cefuroxime axetil	If other, please specify		<input type="text"/>		
Combined duration of antibiotics for this illness					
<input checked="" type="radio"/> <1 month	<input type="radio"/> 1-3 months	<input type="radio"/> >3 months			
Attempts to Contact					
Date.	<input type="text"/>	Time	<input type="text"/>		
<input type="checkbox"/> Left message	<input type="checkbox"/> Home visit	<input type="checkbox"/> Spoke to provider	<input type="checkbox"/> Spoke to health department	<input type="checkbox"/> Other (not listed above)	<input type="checkbox"/> Spoke to client (or designee)
<input type="checkbox"/> Letter sent	<input type="checkbox"/> Unable to reach	<input type="checkbox"/> Spoke to laboratory	If other, please specify		<input type="text"/>
<input type="checkbox"/> Provided by case manager	Services provided by (other than case manager)		<input type="text"/>		
Comments	<input type="text"/>				
<i>After entering information in this section, be sure to click the "Add" button. This will create additional fields for entering additional data. Continue to click the "Add" button after the last entry has been made. FAILURE TO CLICK THE ADD BUTTON WILL RESULT IN LOST DATA.</i>					
<input type="button" value="Add"/>					
Lyme - Health Teaching					
<input type="checkbox"/> Test results or interpretation of test results	<input type="checkbox"/> Treatment options or countermeasures	<input checked="" type="checkbox"/> Fact sheet(s) offered	<input type="checkbox"/> Public health services provided by case manager	<input type="checkbox"/> Disease signs and symptoms	<input type="checkbox"/> Disease prevention measures
Services provided by (other than case manager)		<input type="text"/>			

Arbovirus – Lab/Clinical Tab

Patient

Supplemental

Arb-LabClinical

Arbovirus-Risk

Arb-Intervention

Case Investigation

Arbovirus confirmation criteria

CLINICAL CASE DEFINITION

Neuroinvasive disease--requires the presence of fever and at least one of the following signs and symptoms, as documented by a physician in the absence of a more likely clinical explanation:

- Acutely altered mental status (e.g., disorientation, obtundation, stupor, coma) or
- Other acute signs of central or peripheral neurologic dysfunction (e.g., paresis or paralysis, nerve palsies, sensory deficits, abnormal reflexes, generalized convulsions, abnormal movements) or
- Pleocytosis (increased white blood cell count) in cerebrospinal fluid (CSF) associated with illness clinically compatible with meningitis (e.g., headache or stiff neck).

Non-neuroinvasive disease requires the presence of documented fever, as measured by the patient or clinician, the absence of neuroinvasive disease (above), and the absence of a more likely clinical explanation for the illness. Signs and symptoms may include, fever, headache, stiff neck, myalgias, arthralgias, rash, lymphadenopathy, nausea or vomiting.

Laboratory confirmation criteria

NOTE: an IgG positive result with a corresponding negative IgM result is NOT a case and no follow-up is needed.

CONFIRMED CASE:

- Fourfold or greater change in virus-specific serum antibody titer, or
- Isolation of virus from or demonstration of viral antigen or genomic sequences in tissue, blood, CSF, or other body fluid, or
- Virus-specific immunoglobulin M (IgM) antibodies in CSF by antibody-capture enzyme immunoassay (EIA), or
- Virus-specific IgM antibodies demonstrated in serum by antibody-capture EIA AND confirmed by demonstration of virus specific immunoglobulin G (IgG) antibodies in the same or later specimen by another serologic assay (such as neutralization or hemagglutination inhibition).

PROBABLE CASE:

- Stable (less than or equal to a twofold change), but elevated titer of virus-specific serum antibodies, or
- Virus-specific serum IgM antibodies detected by antibody-capture EIA but with no available results of a confirmatory test in the same or later specimen

Arbovirus case definition

An illness that meets one or more of the above clinical criteria AND one or more of the above laboratory criteria, AND occurred when and where there is a high likelihood of vector activity.

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
LABORATORY INFORMATION W/PROVIDER & FACILITY (SYSTEM)					
Accession Number	Order Result Status	Specimen Collected Date	Specimen Received Date		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Specimen Source	Specimen Body Site				
<input type="text"/>	<input type="text"/>				
TestCode	Resulted Test	Test coding System			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Result	Units	Reference Range			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Organism Code	Resulted Organism	Organism coding System			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Result Date	Performing Facility ID				
<input type="text"/>	<input type="text"/>				
Abnormal Flag	Notes				
<input type="text"/>	<input type="text"/>				
Observation Result Status					
<input type="text"/>					
Provider Name	Provider ID	Order CallBack Phone			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Provider Address	City	State	Zipcode		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Provider County	Provider Fax	Order CallBack E-mail			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Facility Name	Facility ID	Placer Order Number			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Facility Address	City	State	Zipcode		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Facility County	Facility Phone Number	Facility E-mail Address			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Show Results Beginning	<input type="text"/>	<input type="checkbox"/> Show All Results For Patient	<input type="button" value="ADD"/>		

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
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Arbovirus testing (MANDATORY-if not electronic)

Because closely related arboviruses exhibit serologic cross-reactivity, positive results of serologic tests using antigens from a single arbovirus can be misleading. Therefore, it is important to enter ALL tests and their results (positive and negative). Attaching scanned laboratory reports in the WEDSS filing cabinet, when not received electronically, is encouraged.

Date collected	<input type="text"/>		Specimen Source	<input type="text"/>
Arbovirus test method	<input type="text"/>			

CA=California serogroup CHIK = Chikungunya virus DEN=Dengue EEE=Eastern Equine Encephalitis LAC=La Crosse POW=Powassan SLE=St. Louis Encephalitis WNV=West Nile Virus WEE=Western Equine Encephalitis

Arbovirus test	<input type="text"/>	Other test	<input type="text"/>
Arbovirus result	<input type="text"/>	Laboratory Name	<input type="text"/>

After entering information in this section, be sure to click the "Add" button. This will create additional fields for entering additional data. Continue to click the "Add" button after the last entry has been made. FAILURE TO CLICK THE ADD BUTTON WILL RESULT IN LOST DATA.

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
Arbovirus - clinical information					
<i>Fields identified with (linked field) are read only fields populated from corresponding fields on the patient, supplemental, or case investigation tabs.</i>					
Asymptomatic (linked field)	<input type="text" value="False"/>				
Date of onset of symptoms (linked field)	<input type="text"/>				
Patient hospitalized (linked field)	<input type="text"/>				
Date admitted (linked field)	<input type="text"/>		Date discharged (linked field)	<input type="text"/>	
Patient died of this illness (linked field)	<input type="text"/>		Date of death (linked field)	<input type="text"/>	
.....					

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
Fever	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Chills	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Rash	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Headache.	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Photophobia	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Fatigue	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Muscle aches	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Joint pain	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Stiff neck	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Nausea	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Vomiting	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Diarrhea	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Disorientation	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Memory deficit	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Confusion	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Slurred speech	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Coma	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Tremors	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Gait / Balance difficulty	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Specify other symptoms	<input type="text"/>	
.....					
Were the following documented?					
Meningitis documented	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Encephalitis documented	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Acute flaccid paralysis (AFP)	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No			

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
Dengue symptoms (for dengue only)					
Use this section only if the diagnosis is Dengue.					
Previous history of Dengue	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Year Of Previous Dengue	<input type="text"/>	
Petichiae	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Purpura - Ecchymosis	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Vomit with blood	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Blood in stool	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Nasal bleeding	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Bleeding gums	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Blood in urine	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Vaginal bleeding	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Pleural or abdominal effusion	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Conjunctivitis	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Eye pain	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Pallor or cool skin	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Body pain	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Plasma leakage	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Jaundice (icterus)	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Thrombocytopenia	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Rapid, weak pulse	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Narrow pulse pressure	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
<input type="checkbox"/> Other (not listed above)			Specify other symptoms	<input type="text"/>	

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
West Nile virus - history (for West Nile Virus Only)					
Use this section only if there is laboratory confirmation of West Nile Virus from WSLH or CDC.					
Indicate below whether the patient was diagnosed with any of the following medical conditions prior to their West Nile virus infection.					
Diabetes	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Hypertension (high blood pressure)	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Myocardial infarction (heart attack)	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Angina or coronary artery disease	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Congestive heart failure (CHF)	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Chronic obstructive pulmonary disease (COPD)	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Chronic liver disease	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Kidney failure or chronic kidney disease	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Alcoholism	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Bone marrow transplant	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Transplant Type	<input type="text"/>	
Organ transplant	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Transplant year	<input type="text"/>	
Cancer	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Cancer type	<input type="text"/>	

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
Year of cancer diagnosis	<input type="text"/>		Current cancer treatment	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Immunosuppressive condition	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Immunosuppressive condition (specify)	<input type="text"/>	
.....					
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Other cancer treatments	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Hemodialysis	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Other kidney disease treatment	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Steroids-oral or injected (not inhaled or topical)	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Insulin or other diabetic treatment	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Hypertensive (high blood pressure) medication	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Coronary artery disease medication	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
Congestive heart failure medication	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No	Immunosuppressive medication	<input type="radio"/> Yes <input type="radio"/> Unk	<input type="radio"/> No
.....					
Indicate the person or people that provided the information above (check all that apply).					
<input type="checkbox"/> Patient		<input type="checkbox"/> Family member or friend			
<input type="checkbox"/> Provider		<input type="checkbox"/> Medical record			

Arbovirus – Lab/Clinical Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
Arbovirus - analysis FOR STATE USE ONLY					
The following fields are for state use.					
WSLH result summary	<input type="text"/>		CDC result summary	<input type="text"/>	
Testing Laboratory	<input type="text"/>		Arbovirus clinical syndrome	<input type="text"/>	
Other Arbovirus Infection not listed	<input type="text"/>		Imported status (linked field)	<input type="text"/>	

Arbovirus – Risk Tab

Patient

Supplemental

Arb-LabClinical

Arbovirus-Risk

Arb-Intervention

Case Investigation

Arbovirus - blood-organ recipient (MANDATORY)

This section pertains to blood or organ receipt WITHIN 30 DAYS PRIOR TO ILLNESS ONSET.

Did the patient:

Receive blood or blood products (transfusion) Yes No
 Unk

If yes, notify the WI Division of Public Health by phone.

Transfusion Date from  Transfusion Date to 

Receive organ transplant Yes No
 Unk Date of organ transplant 

[Update: West Nile Virus Screening of Blood Donations and Transfusion-Associated Transmission Blood Transfusion, Organ Donation and Blood Donation Screening Information](#)

Arbovirus - travel

This section pertains to travel during the TWO WEEKS PRIOR to illness--excluding normal daily travel.

Did patient travel Yes No
 Unk

Travel start date  Travel end date 

Travel Location

After entering information in this section, be sure to click the "Add" button. This will create additional fields for entering additional data. Continue to click the "Add" button after the last entry has been made. FAILURE TO CLICK THE ADD BUTTON WILL RESULT IN LOST DATA.

Add

Arbovirus – Risk Tab

Patient

Supplemental

Arb-LabClinical

Arbovirus-Risk

Arb-Intervention

Case Investigation

Arbovirus - mosquito exposure

This section pertains to mosquito and/or tick exposure or bites within the 14 DAYS PRIOR TO ILLNESS ONSET.

Mosquito exposure or bites Yes, bites Yes, exposure only No exposure Unk

Tick exposure or bites Yes, bites Yes, exposure only No exposure Unk

DEET Use When
Outdoors More Than 30
Minutes

Arbovirus - occupational exposure

Laboratory acquired infection Yes No Unk

Person fell ill with illness that was likely acquired due to work with infectious agents in a laboratory setting.

Non-laboratory occupationally acquired infection Yes No Unk

Possible infection in an occupational setting that is not a laboratory.

Location (name and address)

Director/supervisor contact information

Director/supervisor notified

West Nile virus - infected infant

Infected in utero Yes No Unk

Infant that was born to a mother who had a [West Nile virus](#) illness/infection during her pregnancy.

Breast fed infant Yes No Unk

Person who fell ill with West Nile virus and was breast fed prior to illness onset.

Arbovirus – Intervention Tab

Patient	Supplemental	Arb-LabClinical	Arbovirus-Risk	Arb-Intervention	Case Investigation
Arbovirus - blood-organ donation (MANDATORY)					
This section pertains to blood or organ donation WITHIN 30 DAYS PRIOR TO ILLNESS ONSET.					
Did the patient:					
Donate blood or blood products	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> Unk		
<i>If yes, notify the WI Division of Public Health by phone.</i>					
Date of blood donation	<input type="text" value="6/11/2010"/>				
Infection identified by donor screening	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> Unk	<i>Donor identified as having a West Nile virus infection through routine blood donation screening by the blood collection agency.</i>	
Donate organs	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> Unk	Date of organ donation	<input type="text" value="6/11/2010"/>
Blood or organ collection agency	<input type="text" value="arafs"/>		Director/supervisor contact information	<input type="text"/>	
<input checked="" type="checkbox"/> Director/supervisor notified					
Update: West Nile Virus Screening of Blood Donations and Transfusion-Associated Transmission Blood Transfusion, Organ Donation and Blood Donation Screening Information					
Arbovirus - pregnancy and lactation					
<i>Fields identified with (linked field) are read only fields populated from corresponding fields on the patient, supplemental, or case investigation tabs.</i>					
Pregnant (linked field)	<input type="text"/>		Estimated delivery date (linked field)	<input type="text"/>	
Breast feeding at onset of symptoms	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unk		
Recommended clinical evaluation of infants born to mothers infected with West Nile virus (WNV) during pregnancy					
West Nile Virus (WNV) Infection and Breastfeeding					

Arbovirus – Intervention Tab

Patient

Supplemental

Arb-LabClinical

Arbovirus-Risk

Arb-Intervention

Case Investigation

Attempts to Contact

Date.

Time

Left message

Letter sent

Home visit

Unable to reach

Spoke to provider

Spoke to laboratory

Spoke to health department

Other (not listed above)

If other, please specify

Spoke to client (or designee)

Provided by case manager

Services provided by
(other than case manager)

Comments

After entering information in this section, be sure to click the "Add" button. This will create additional fields for entering additional data. Continue to click the "Add" button after the last entry has been made. FAILURE TO CLICK THE ADD BUTTON WILL RESULT IN LOST DATA.

Add

Health teaching

Test results or interpretation of test results

Disease signs and symptoms

Treatment options or countermeasures

Disease prevention measures

Fact sheet(s) offered

If other, please specify

Public health services provided by case manager

Services provided by
(other than case manager)