FLORIDA CONFIDENTIAL ARBOVIRAL INFECTION CASE REPORT

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

☐St. Louis Encephalitis ☐Eastern Equine Encephalomyelitis ☐Dengue
☐West Nile Virus Neuroinvasive ☐West Nile Fever ☐LaCrosse/CA Encephalitis

IDENTIFYING DATA: County: _____ Merlin Case #: _____

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

Home Address: _____ Homeless ☐Yes ☐No
Street City State Zip

Home Phone: (____)_____ Employer/School: _____
Name address zip

Race ☐White ☐Black ☐Hispanic ☐Asian/Pacific Islander SSN#_____
☐American Indian/Alaska Native ☐Unknown/Not specified

Hospitalization: ☐ 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	☐	☐	☐	Rigidity	☐	☐	☐
Highest Temp. (If known)	_____ºF			Delirium	☐	☐	☐	Cranial Nerve Palsy	☐	☐	☐
Headache	☐	☐	☐	Lethargy	☐	☐	☐	Rash	☐	☐	☐
Stiff Neck	☐	☐	☐	Stupor	☐	☐	☐	Convulsion	☐	☐	☐
Tremor	☐	☐	☐	Coma	☐	☐	☐	Paralysis	☐	☐	☐
Vomiting	☐	☐	☐	Muscle Weakness	☐	☐	☐	Hemorrhage	☐	☐	☐
Confusion	☐	☐	☐	Hyperreflexia	☐	☐	☐	Other_____			

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

LABORATORY DATA: (*must attach laboratory sheets)**

Acute specimens must be collected within 14 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

***Tampa or Jacksonville DOH state lab reports 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 ☐ Unk
5. Does the patient use any prevention measures to avoid mosquito bites (5 D's)? ☐ Yes ☐ No
   If yes, list_____
   Does the patient use mosquito repellant when outdoors: ☐Always ☐Sometimes ☐Rarely ☐Never
   Does the repellant 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 ☐ Unk
   If yes, specify when and where: _____
8. Has the patient traveled outside the U.S. in the two weeks prior to onset? ☐ Yes ☐ No ☐ Unk
   If yes, specify when and where: _____
9. Does the patient have any underlying medical conditions? ☐ Yes ☐ No ☐ Unk
   If yes, specify _____
10. What is the patient's occupation?_____

BLOOD DONATION/TRANSFUSION/TRANSPLANT HISTORY/PREGNANCY:

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

VACCINE INFORMATION

15. Has patient received yellow fever (YF) vaccine? ☐Yes (date:__/__/__) ☐No ☐Unk
16. Has patient received Japanese encephalitis (JE) vaccine? ☐Yes (date:__/__/__)☐No ☐Unk
17. Has patient received Central European encephalitis (CEE) vaccine? ☐Yes (date:__/__/__)
    ☐No ☐Unk

COMMENTS: _____

_____

_____

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

Please submit form to the Bureau of Community Environmental Health (HSEC), Dept. of Health, 4052 Bald Cypress Way, Bin A-08, Tallahassee, Florida 32399-1712 or FAX 850-922-8473 or SC 292-8473.

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