



PATIENT INFORMATION

First Name: _____ Middle Name: _____
Last Name: _____ Suffix: _____
Country of birth: _____
Date of birth: _____ Reported age: _____
Current Sex: Female Male Unknown

Is the patient deceased? Yes No Unknown If yes, deceased date: _____
Marital status: Annulled Divorced Domestic partner Interlocutory Legally separated
 Married Polygamous Refused to answer Single, never married
 Unknown Widowed

Address information

Street Address: _____
City: _____
State: _____
Zip: _____
County: _____
Country: _____

Home phone: _____
Work phone: _____
Ext: _____
Cell phone: _____
Email: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race (Select all that apply): American Indian or Alaska Native
 Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White
 Unknown



CASE INFORMATION

Investigator information

Jurisdiction: Investigation start date:
Investigator Name: Date assigned to investigation:
Date of report:
Earliest date reported to county:
Earliest date reported to state:

- Reporting source type: Blood bank, Correctional facilities, Data registries, Daycare facility, Dentist, Drug treatment facility, Emergency room/emergency department, Family planning facility, Hospital, Indian Health Service, Laboratory, Managed Care/HMOs, Military, National job training program, Other federal agencies, Other state or local agencies, Other treatment center, Pharmacy, Prenatal/Obstetrics facility, Private physician's office, Public health clinic, Public health clinic - HIV, Public health clinic- STD, Public health clinic - TB, Rural health clinic, School clinic, Tribal government, Veterinary sources, Vital statistics

Reporting organization:
Address:

Reporting provider:
Address:

Clinical Information

Physician:
Address:

Was the patient hospitalized for this illness? Yes No Unknown
If yes, name of hospital:
Admission date: Discharge date:
Total duration of stay:

- Type of arbovirus: Arbovirus, Cache valley virus, California encephalitis virus, Chikungunya virus, Colorado tick fever virus, Dengue virus, Eastern equine encephalitis virus, Flavivirus, Jamestown Canyon virus, Japanese encephalitis virus, La Crosse virus, Powassan virus, St. Louis encephalitis virus, Venezuelan equine encephalomyelitis virus, West Nile, Western equine encephalitis virus, Yellow fever, Zika virus



- Clinical syndrome (Select one):
Acute flaccid paralysis
Asymptomatic
Congenital infection
Dengue
Dengue-like illness
Encephalitis - including meningioencephalitis
Febrile illness
Guillain-Barre syndrome
Hepatitis/Jaundice
Meningitis
Multiple organ failure
Other clinical
Other neuroinvasive presentation
Unknown

If Other clinical, note syndrome: _____

- Clinical syndrome, secondary (Select one):
Acute flaccid paralysis
Encephalitis - including meningioencephalitis
Guillain-Barre syndrome
Hepatitis/Jaundice
Meningitis
Multi-system organ failure
None
Other clinical
Other neuroinvasive presentation

If Other clinical, note syndrome: _____

Diagnosis date: _____ Illness onset date: _____
Illness end date: _____ Illness duration: _____
Age at onset: _____ Did the patient die from this illness? Yes No Unknown
If yes, date of death: _____

Pregnancy and birth information

Is the patient pregnant? Yes No Unknown If yes, due date: _____
Pregnancy complications (Select all that apply):

- Fetal growth abnormality
Fetus with Central Nervous System (CNS) abnormalities
Intracranial calcification
Microcephaly

Pregnancy outcome (Select one):
Delivery (live birth)
Fetal death (fetal loss)
Perinatal death
Premature death of newborn
Still pregnant
Stillbirth (Intrauterine fetal death)
Therapeutic termination of pregnancy

Mother's last menstrual period before delivery: _____

Newborn complications (Select all that apply):
Congenital anomaly of central nervous system
Intracranial calcification
Intrauterine Growth Retardation (IUGR)
Limb defects
Microcephaly
None
Ocular defects

Mother-infant case ID linkage 1: _____
Mother-infant case ID linkage 2: _____
Mother-infant case ID linkage 3: _____

Signs and symptoms

Fever: Yes No Unknown
Chills or rigors: Yes No Unknown
Fatigue or malaise: Yes No Unknown



- Rash: Yes No Unknown
- Headache: Yes No Unknown
- Myalgia: Yes No Unknown
- Arthralgia: Yes No Unknown
- Arthritis: Yes No Unknown
- Paralysis or paresis: Yes No Unknown
- Stiff neck: Yes No Unknown
- Ataxia: Yes No Unknown
- Parkinsonism or cogwheel rigidity: Yes No Unknown
- Altered mental status: Yes No Unknown
- Seizures: Yes No Unknown
- Conjunctivitis: Yes No Unknown
- Retro-orbital pain: Yes No Unknown
- Nausea or vomiting: Yes No Unknown
- Diarrhea: Yes No Unknown
- Abdominal pain or tenderness: Yes No Unknown
- Persistent vomiting: Yes No Unknown
- Liver enlargement (hepatomegaly): Yes No Unknown
- Oral ulcer: Yes No Unknown
- Extravascular fluid accumulation: Yes No Unknown
- Mucosal bleeding: Yes No Unknown
- Severe plasma leakage: Yes No Unknown
- Sever bleeding: Yes No Unknown
- Tourniquet test positive: Yes No Unknown
- Increasing hematocrit and decreased platelet: Yes No Unknown
- Sever organ involvement: Yes No Unknown
- Leukopenia: Yes No Unknown
- Other symptoms: _____

Epidemiologic

Is this case part of an outbreak? Yes No Unknown

If yes, outbreak name: _____

Did the patient travel outside home COUNTY in the two weeks before symptom onset?

Yes No Unknown If yes, where to and when: _____

Where was the disease acquired? (Select one)

- Imported, but not able to determine source state and/or county
- In state, out of jurisdiction
- Indigenous
- International
- Out of state
- Unknown



If disease was acquired [In state, out of jurisdiction] or [International] or [Out of State], please fill in location:

Country: _____ State: _____

City: _____ County: _____

Country of usual residence: _____

Has the patient spent extended time outdoors in the 2 weeks prior to onset? Yes No Unknown

Has the patient traveled outside Maryland in the 2 weeks prior to onset? Yes No Unknown

If yes, specify when and where (geographic location): _____

Binational reporting criteria (Select all that apply):

- Exposure to suspected product from Canada or Mexico
- Has case contacts in or From Mexico or Canada
- Other situations that may require binational notification/coordination of response
- Potentially exposed by a resident of Mexico or Canada
- Potentially exposed while in Mexico or Canada
- Resident of Canada or Mexico

Occupationally lab acquired: Yes No Unknown

Identified by blood donor screening: Yes No Unknown

Blood donor: Yes No Unknown

If yes, specify (donated blood products in the 2 weeks prior to onset of symptoms): _____

Date of donation: _____

Blood transfusion received: Yes No Unknown

Organ donor: Yes No Unknown

Organ transplant received: Yes No Unknown

Breast fed infant: Yes No Unknown

Arboviral disease transmission mode (Select one):

- Blood borne transmission In-Utero (Transplacental)
- Indeterminate transmission mode Other Perinatal exposure
- Sexual transmission Vector-borne transmission

Infected in utero: Yes No Unknown

Ill Contact Name	Ill Contact Phone Number

Laboratory findings

Test Type	Result	Specimen Type	Collection Date	Performing Lab Type



Cerebrospinal fluid (CSF) pleocytosis (≥5WBC): Yes No
Serum paired antibody test interpretation: ≥ 4 fold rise Negative Positive Test not done
Deng (DENV) serotype (for Dengue only): Type 1 Type 2 Type 3 Type 4 Unknown

Vaccination Status

Did the patient ever receive vaccine for:

Yellow fever Yes No Unknown If Yes, date: _____
Japanese encephalitis Yes No Unknown If Yes, date: _____
Tick-borne encephalitis Yes No Unknown If Yes, date: _____

For Zika only:

Sexual contact with anyone who traveled to or resided in an area with active/endemic transmission?
 Yes No Unknown

If Yes, partner's travel from date: _____ Partner's travel to date: _____

If Yes, partner's travel location(s): _____

If Yes, was the sexual partner symptomatic during or within 2 weeks after travel?
 Yes No Unknown If Yes, partner's date of onset: _____

Date of last sexual contact (if known): _____

Name of sexual partner: _____

General comments

Five horizontal lines for general comments.