

# CASE REPORT FORM

# Arboviral Disease

Arboviral Disease _____		EpiSurv No. _____	
<b>Disease Name</b>			
<input type="radio"/> Dengue fever	<input type="radio"/> Barmah Forest virus infection	<input type="radio"/> Murray Valley encephalitis	
<input type="radio"/> Ross River virus infection	<input type="radio"/> Japanese encephalitis	<input type="radio"/> Yellow fever	
<input type="radio"/> Kunjin	<input type="radio"/> Lyme disease	<input type="radio"/> Chikungunya fever	
<b>Reporting Authority</b>			
Name of Public Health Officer responsible for case _____			
<b>Notifier Identification</b>			
Reporting source* <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory			
<input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other			
Name of reporting source _____		Organisation _____	
Date reported* _____		Contact phone _____	
Usual GP _____		Practice _____	
		GP phone _____	
GP/Practice address Number _____ Street _____ Suburb _____			
Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
<b>Case Identification</b>			
Name of case* Surname _____		Given Name(s) _____	
NHI number* _____		Email _____	
Current address* Number _____ Street _____ Suburb _____			
Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
Phone (home) _____		Phone (work) _____	
		Phone (other) _____	
<b>Case Demography</b>			
Location TA* _____		DHB* _____	
Date of birth* _____		OR Age _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	
Sex* <input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Indeterminate <input type="radio"/> Unknown	
Occupation* _____			
Occupation location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____ Street _____ Suburb _____			
Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
Alternative location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____ Street _____ Suburb _____			
Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
<b>Ethnic group case belongs to*</b> (tick all that apply)			
<input type="checkbox"/> NZ European	<input type="checkbox"/> Maori	<input type="checkbox"/> Samoan	<input type="checkbox"/> Cook Island Maori
<input type="checkbox"/> Niuean	<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian	<input type="checkbox"/> Tongan
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)		*(specify) _____	

**Basis of Diagnosis**

**CLINICAL CRITERIA**

**Fits Clinical Description\***                       Yes                       No                       Unknown

**Clinical features**

Main clinical syndrome (tick appropriate options(s))

- Encephalitis: acute central nervous system disease with aseptic meningitis or encephalitis
- Fever with or without an exanthem
- Arthritis and rash

Clinical comments  
 \_\_\_\_\_  
 \_\_\_\_\_

**LABORATORY CRITERIA**

**Laboratory confirmation of disease\***                       Yes     No     Not Done     Awaiting Results

If yes, specify method of laboratory confirmation (tick all that apply)

- Isolation of virus from a clinical specimen                       Yes     No     Not Done     Awaiting Results
- Positive IgM antibody                       Yes     No     Not Done     Awaiting Results  
 If yes, has the IgM been confirmed as a true positive by an overseas laboratory?                       Yes     No     Not Done     Awaiting Results
- Positive IgG antibody                       Yes     No     Not Done     Awaiting Results
- Significant rise in IgG antibody level                       Yes     No     Not Done     Awaiting Results
- Other positive test (specify) \_\_\_\_\_

**STATUS\***     Under investigation     Probable     Confirmed     Not a case

**ADDITIONAL LABORATORY DETAILS**

Serotype\* \_\_\_\_\_

If dengue, is there evidence of a previous dengue infection?\*     Yes                       No                       Unknown

**Clinical Course and Outcome**

**Date of onset\***    \_\_\_\_\_                       Approximate                       Unknown

**Hospitalised\***                       Yes                       No                       Unknown

**Date hospitalised\***    \_\_\_\_\_                       Unknown

**Hospital\*** \_\_\_\_\_

**Died\***                       Yes                       No                       Unknown

**Date died\***                      \_\_\_\_\_                       Unknown

**Was this disease the primary cause of death?\***     Yes                       No                       Unknown

**If no, specify the primary cause of death\***  
 \_\_\_\_\_  
 \_\_\_\_\_

**Outbreak Details**

**Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?\***

Yes                      **If yes, specify Outbreak No.\*** \_\_\_\_\_

**Risk Factors**

Was the case overseas during the incubation period for this disease? \*  Yes  No  Unknown

If yes, date arrived in New Zealand\* \_\_\_\_\_

Specify countries visited\* (from most recent to least recent)

Country/Region\*

Date Entered\*

Date Departed\*

Last: \*

Second Last: \*

Third Last: \*

Country/region where arboviral disease probably acquired\* \_\_\_\_\_

If the case has not been overseas recently, is there any prior history of overseas travel that might account for this infection? \*  Yes  No  Unknown

If yes, give details of travel\* \_\_\_\_\_

Did the case travel within New Zealand during the 15 days before becoming ill? \*  Yes  No  Unknown

Specify where in NZ the case travelled\* \_\_\_\_\_

Does the case's occupation involve contact with imported goods (e.g. imported machinery, tyres)? \*  Yes  No  Unknown

Other risk factors for disease\* \_\_\_\_\_

**Protective Factors**

Prior to onset, had the case been immunised with appropriate vaccine? \*  Yes  No  NA  Unknown

If yes, specify date of last vaccination\* \_\_\_\_\_

Unknown

If yes, specify how vaccination status was confirmed? \*

Patient/caregiver recall

Documented

Did the case take any of the following precautions: \*

Use of insect repellents\*  Always  Occasionally  Rarely  Never

Use of bed nets\*  Always  Occasionally  Rarely  Never

Screened/air conditioned accommodation\*  Always  Occasionally  Rarely  Never

Wearing of long sleeved shirts and trousers\*  Always  Occasionally  Rarely  Never

Any other precautions against biting insects\*  Always  Occasionally  Rarely  Never

Specify\* \_\_\_\_\_

**Comments\***