

# Venezuelan Equine Encephalitis (VEE)

## FOR STATE USE ONLY

Investigator: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone number: \_\_\_\_\_

Status:  Confirmed  Suspect  
 Probable  Not a case

Reviewer initials: \_\_\_\_\_  
Referred to another state: \_\_\_\_\_

### CASE

Last name: \_\_\_\_\_

First and middle name: \_\_\_\_\_

Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Address line: \_\_\_\_\_

Zip: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

Long-term care resident:  Yes  No  Unknown

Facility name: \_\_\_\_\_

Facility phone: ( )- - Type: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_

Gender:  Female  Male  Other \_\_\_\_\_

Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Marital status:  Single  Parent with partner  Widowed  
 Married  Separated

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

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Parent/Guardian name: \_\_\_\_\_

Parent/Guardian phone: ( )- - Type: \_\_\_\_\_

### EVENT

Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown

Outbreak related:  Yes  No  Unknown

Outbreak name: \_\_\_\_\_

Exposure setting: \_\_\_\_\_

Epi-linked:  Yes  No  Unknown

Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown

State: \_\_\_\_\_ Country: \_\_\_\_\_

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Provider type:  ARNP  MD  
 DO  NP  PA

Facility name: \_\_\_\_\_

Address line 1: \_\_\_\_\_

Address line 2: \_\_\_\_\_

Zip code: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

Phone: ( )- - Type: \_\_\_\_\_

Healthcare provider information

### LABORATORY FINDINGS

Laboratory: _____	Specimen source: _____	Test type: <input type="checkbox"/> Serology (ELISA) <input type="checkbox"/> PCR <input type="checkbox"/> Other _____
Accession #: _____	Result date: ____ / ____ / ____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final
Collection date: ____ / ____ / ____	Test type: <input type="checkbox"/> Acute <input type="checkbox"/> IgM <input type="checkbox"/> Convalescent <input type="checkbox"/> IgG	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Date received: ____ / ____ / ____	Organism: <b>Venezuelan Equine virus</b>	Type: _____

Laboratory: _____	Specimen source: _____	Test type: <input type="checkbox"/> Serology (ELISA) <input type="checkbox"/> PCR <input type="checkbox"/> Other _____
Accession #: _____	Result date: ____ / ____ / ____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final
Collection date: ____ / ____ / ____	Test type: <input type="checkbox"/> Acute <input type="checkbox"/> IgM <input type="checkbox"/> Convalescent <input type="checkbox"/> IgG	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Date received: ____ / ____ / ____	Organism: <b>Venezuelan Equine virus</b>	Type: _____

Laboratory: _____	Specimen source: _____	Test type: <input type="checkbox"/> Serology (ELISA) <input type="checkbox"/> PCR <input type="checkbox"/> Other _____
Accession #: _____	Result date: ____ / ____ / ____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final
Collection date: ____ / ____ / ____	Test type: <input type="checkbox"/> Acute <input type="checkbox"/> IgM <input type="checkbox"/> Convalescent <input type="checkbox"/> IgG	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Date received: ____ / ____ / ____	Organism: <b>Venezuelan Equine virus</b>	Type: _____

**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: \_\_\_\_\_ Job title: \_\_\_\_\_  
 Worked after symptom onset:  Yes  No  Unknown Facility name: \_\_\_\_\_  
 Date worked from: \_\_\_\_/\_\_\_\_/\_\_\_\_ Address: \_\_\_\_\_  
 Date worked to: \_\_\_\_/\_\_\_\_/\_\_\_\_ Zip code: \_\_\_\_\_  
 Removed from duties:  Yes  No  Unknown City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_  
 Date removed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_

Handle food:  Yes  No  Unknown  
 Attend or provide child care:  Yes  No  Unknown  
 Attend school:  Yes  No  Unknown  
 Work in a lab setting:  Yes  No  Unknown

Work in a health care setting:  Yes  No  Unknown  
 Direct patient care duties:  Yes  No  Unknown  
 Health care worker type: \_\_\_\_\_

Occupation type: \_\_\_\_\_ Job title: \_\_\_\_\_  
 Worked after symptom onset:  Yes  No  Unknown Facility name: \_\_\_\_\_  
 Date worked from: \_\_\_\_/\_\_\_\_/\_\_\_\_ Address: \_\_\_\_\_  
 Date worked to: \_\_\_\_/\_\_\_\_/\_\_\_\_ Zip code: \_\_\_\_\_  
 Removed from duties:  Yes  No  Unknown City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_  
 Date removed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_

Handle food:  Yes  No  Unknown  
 Attend or provide child care:  Yes  No  Unknown  
 Attend school:  Yes  No  Unknown  
 Work in a lab setting:  Yes  No  Unknown

Work in a health care setting:  Yes  No  Unknown  
 Direct patient care duties:  Yes  No  Unknown  
 Health care worker type: \_\_\_\_\_

**HOSPITALIZATIONS**

Was the case hospitalized?  Yes  No  Unknown

Hospital: \_\_\_\_\_ Isolated at entry:  Yes  No  Unk Isolation type (entry): \_\_\_\_\_  
 Admission date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Days hospitalized: \_\_\_\_\_  
 Currently isolated:  Yes  No  Unk Current isolation type: \_\_\_\_\_

**CLINICAL INFO & DIAGNOSIS**

**Physician diagnosis:**  Encephalitis  Asymptomatic  Dengue hemorrhagic fever/ Dengue shock **Clinical classification:**  Neuroinvasive  Non-neuroinvasive  
 Meningitis  Hepatitis/jaundice  
 Meningoencephalitis  Multi-system organ failure  
 Fever  Other \_\_\_\_\_

**Symptoms:**  Acute flaccid paralysis  Diarrhea  Headache  Stiff neck  
 Altered mental state  Double vision  Joint pain  Swollen lymph nodes  
 Anorexia  Eye pain  Muscle pain  Tremors  
 Coma  Fatigue  Nausea  Vertigo  
 Confusion  Fever  Photophobia  Vomiting  
 Cranial nerve palsies  Gait/balance difficulty  Rash  Other symptoms: \_\_\_\_\_

**Pre-existing Conditions**

Before your West Nile virus (WNV) infection, did a health care provider ever tell he/she had any of the following medical conditions?

Diabetes  Congestive heart failure  Kidney disease or failure  
 High blood pressure (hypertension)  Stroke  Bone marrow transplant  
 Heart attack (myocardial infarction)  Chronic obstructive pulmonary disease (COPD)  Alcoholism  
 Angina or coronary artery disease  Chronic liver disease  Case had none of the conditions listed

Before WNV infection, did the case ever have a solid organ transplant?  Yes  No  Unk

If yes, what organ was transplanted: \_\_\_\_\_

If yes, what year was the transplant: \_\_\_\_\_

Before WNV infection, has the case ever had cancer?  Yes  No  Unk

If yes, what cancer type(s): \_\_\_\_\_

If yes, what year were you diagnosed: \_\_\_\_\_

If yes, are you currently being treated for cancer:  Yes  No  Unk

Before WNV infection, did the case have any medical condition that limited his/her ability to fight infection?  Yes  No  Unk

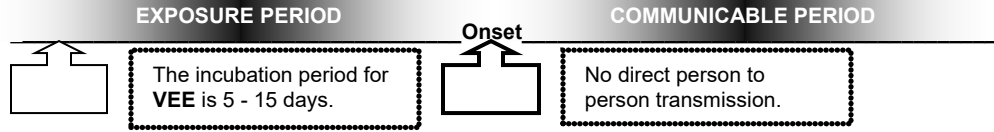
If yes, what condition: \_\_\_\_\_

At the time WNV infection was diagnosed, was the case taking any of the following types of prescription medications or treatments?

- Chemotherapy, Oral or injected steroids, Medications to treat coronary artery disease, Other treatments for cancer, Inhaled steroids, Medications to treat congestive heart failure, Hemodialysis, Insulin or other medications to treat diabetes, Medications that suppress the immune system, Other treatments for kidney disease, Medications to treat high blood pressure, Case was not on any medication/treatments listed

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Ever vaccinated for Yellow Fever or Japanese encephalitis (JE)?  Yes  No  Unknown

If yes, list MOST RECENT vaccination information ONLY:

Two columns of vaccination information forms. Each includes fields for Disease (Yellow fever, JE), Date vaccinated, Lot #, Vaccine type, and Manufacturer.

Number of vaccinations: \_\_\_\_\_

Risk Factors/Travel Information

In the 15 days prior to onset of symptoms did the case:

Travel information forms including 'Traveled within Iowa?', 'Traveled within U.S.?', 'Traveled outside U.S.?' and corresponding departure/return dates.

Exposed to mosquitoes:  Yes  No  Unk

Use a mosquito repellent:  Yes  No  Unk. If yes, how often?  Sometimes  Never  Always  Most of the time. If yes, what type?  Picaridin  DEET  Oil of lemon eucalyptus  Other \_\_\_\_\_

If the patient is female, was she:

Pregnant?  Yes  No  Unk
Breastfeeding?  Yes  No  Unk

In the 30 days prior to onset of symptoms did the case:

Forms for 'Donate blood, blood products, organs or tissues?', 'Receive blood or blood products?', 'Receive organs or tissue?', and 'Case acquired infection?' (Naturally, Transplantation, Transfusion, Trans-placental, Breastfeeding, Occupationally, Unknown).

NOTES: \_\_\_\_\_