Yellow Fever

Investigator:
Agency: **Phone number:**

FOR STATE USE ONLY

Status: ☐ Confirmed ☐ Suspect ☐ Probable ☐ Not a case

Reviewer initials:
Referred to another state:

CASE

Last name: _____ Date of Birth: __/__/__ Estimated? ☐ Age: _____

First and middle name: _____ Gender: ☐ Female ☐ Male ☐ Other _____

Maiden name: _____ Suffix: _____ Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: __/__/__

Address line: _____ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed

Zip: _____ City: _____ Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian

State: _____ County: _____

Long-term care resident: ☐ Yes ☐ No ☐ Unknown Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Facility name: _____ Parent/Guardian name: _____

Facility phone: (___)___-____ Type: _____ Parent/Guardian phone: (___)___-____ Type: _____

EVENT

Onset date: __/__/__ Diagnosis date: __/__/__

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death __/__/__

Event exception
☐ Case could not be found
☐ Case could not be interviewed
☐ Case refused interview
☐ Other – see notes

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: _____

Healthcare provider information

Last name: _____

First name: _____

Provider type: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____ City: _____

State: _____ County: _____

Phone : (___)___-____ Type: _____

LABORATORY FINDINGS

Laboratory: _____ Specimen source: _____ Test type: ☐ Serology (ELISA) ☐ PCR ☐ Other _____

Accession #: _____ Result date: __/__/__ Result type: ☐ Preliminary ☐ Final

Collection date: __/__/__ Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG Result: ☐ Negative ☐ Equivocal ☐ Positive ☐ Indeterminate

Date received: __/__/__ Organism: **Yellow fever virus** Type:

Laboratory: _____ Specimen source: _____ Test type: ☐ Serology (ELISA) ☐ PCR ☐ Other _____

Accession #: _____ Result date: __/__/__ Result type: ☐ Preliminary ☐ Final

Collection date: __/__/__ Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG Result: ☐ Negative ☐ Equivocal ☐ Positive ☐ Indeterminate

Date received: __/__/__ Organism: **Yellow fever virus** Type:

Laboratory: _____ Specimen source: _____ Test type: ☐ Serology (ELISA) ☐ PCR ☐ Other _____

Accession #: _____ Result date: __/__/__ Result type: ☐ Preliminary ☐ Final

Collection date: / / Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG Result: ☐ Negative ☐ Positive ☐ Equivocal ☐ Indeterminate

Date received: / / Organism: **Yellow fever virus** 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
☐ Meningitis
☐ Meningoencephalitis
☐ Fever
☐ Asymptomatic
☐ Hepatitis/jaundice
☐ Multi-system organ failure
☐ Other _____
☐ Dengue hemorrhagic fever/ Dengue shock

Clinical classification:
☐ Neuroinvasive
☐ Non-neuroinvasive

Symptoms:
☐ Acute flaccid paralysis
☐ Altered mental state
☐ Anorexia
☐ Coma
☐ Confusion
☐ Cranial nerve palsies
☐ Diarrhea
☐ Double vision
☐ Eye pain
☐ Fatigue
☐ Fever
☐ Gait/balance difficulty
☐ Headache
☐ Joint pain
☐ Muscle pain
☐ Nausea
☐ Photophobia
☐ Rash
☐ Stiff neck
☐ Swollen lymph nodes
☐ Tremors
☐ Vertigo
☐ Vomiting
☐ 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
☐ High blood pressure (hypertension)
☐ Heart attack (myocardial infarction)
☐ Angina or coronary artery disease
☐ Congestive heart failure
☐ Stroke
☐ Chronic obstructive pulmonary disease (COPD)
☐ Chronic liver disease
☐ Kidney disease or failure
☐ Bone marrow transplant
☐ Alcoholism
☐ 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

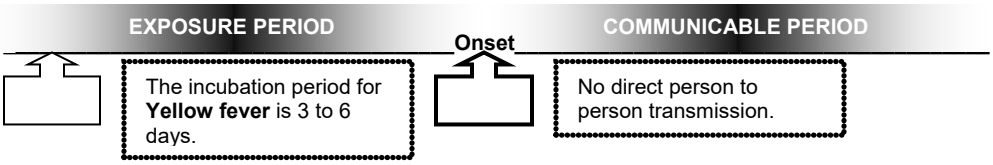
Before WNV infection, did the case have any medical condition that limited his/her ability to fight infection? ☐ Yes ☐ No ☐ Unk **If yes, what condition:**

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:

Disease:	☐ Yellow fever ☐ JE	☐ Yellow fever ☐ JE
Date vaccinated:	/ /	/ /
Lot #:		
Vaccine type:		
Manufacturer:		

Number of vaccinations: ____

Risk Factors/Travel Information

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

Travel within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: _____ — Departure date: / / — Return date: / /

Travel within U.S.? ☐ Yes ☐ No ☐ Unk — State: _____ City: _____ — Departure date: / / — Return date: / /

Travel outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: _____ — Departure date: / / — Return date: / /

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

NOTES: _____