EPI-2
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Dengue, Chikungunya and Zika Reporting Form

US Virgin Islands Department of Health, Epidemiology Division
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Form is published at http://doh.vi.gov/forms
Click here for direct download

Case Number	Specimen #	Days Post Onset (DPO)	Type	Date Received	Specimen #	Days Post Onset (DPO)	Type	Date Received
SAN ID / GCODE	S1				S3			
	S2				S4			

PLEASE READ AND COMPLETE ALL SECTIONS *especially those marked with an asterisk*

Select suspected disease: ☐ Dengue ☐ Chikungunya ☐ Zika

Today's Date: _____ (mm/dd/yyyy)

Island: ☐ St. Croix ☐ St. John ☐ St. Thomas ☐ Water Island

Patient Data

Hospitalized due to this illness? ☐ No ☐ Yes → If yes, hospital name: Record Number:

Patient Name (Last) **(First)** **(MI)**

Fatal? ☐ Yes ☐ No ☐ Unk

Mental Status Change? ☐ Yes ☐ No ☐ Unk

Parent/Guardian (if applicable):

Home, Physical Address (indicate ESTATE)

Residence is close to:

City Zip Code

***Phone:** Other Phone:

***Email:** Work Address:

Physician Who Referred This Case

Physician Name:

Physician Address:

Physician Phone:** ***Fax:

Email:

Patient's Demographic Information

***Date of Birth** (mm/dd/yyyy)

Age (months or years) _____ months _____ years

Gender: ☐ M ☐ F ☐ Other

Pregnant? ☐ Yes ☐ No ☐ Unk
Weeks pregnant (gestation):
EDD:

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Race: ☐ Black ☐ White ☐ Asian ☐ Unknown ☐ Other:

Who filled out this form? Name (complete): Relationship with patient:

Telephone: Fax: Email:

Must Have the Following Information for Sample Processing

***Date of first symptom** (mm/dd/yyyy)

***Date specimen taken**

First sample (mm/dd/yyyy)

Second sample (mm/dd/yyyy)

How long have you lived in this city? _____ **Country of Birth:** _____

During the 14 days before onset of illness, did you TRAVEL to other cities or countries?

☐ Yes, another country ☐ Yes, another city ☐ No ☐ Unk

Where did you travel?

Are there any sick contacts in your household? ☐ Yes ☐ No

PLEASE indicate below the signs and symptoms that the patient had at the time of illness

	Yes	No	Unk
Fever lasting 2-7 days			
*Fever (>38°C/101°F)			
Platelets ≤100,000/mm3			
Platelets Count _____			
Any Hemorrhagic Manifestation			
Petechiae			
Purpura/Ecchymosis			
Vomit with blood			
Blood in stool			
Nasal bleeding			
Bleeding gums			
Blood in urine			
Vaginal bleeding			
Positive urinalysis (over 5 RBC/hpf or positive for blood)			

Tourniquest Test ☐ Positive ☐ Negative ☐ Not done

Evidence of Capillary Leak

Lowest Hematocrit _____ (%)
Highest Hematocrit _____ (%)
Lowest Serum Albumin _____
Lowest Serum Protein _____
Lowest Blood Pressure (SBP/DBP) _____/_____
Lowest Pulse Pressure (systolic-diastolic) _____
Lowest white blood cell count (WBC) _____

Symptoms	Yes	No	Unk
Rapid, weak pulse			
Pallor or cool skin			
Chills			
Rash			
Headache			
Eye pain			
Body (muscle/bone) pain			
*Joint pain			
Anorexia			

Warning Signs	Yes	No	Unk
Persistent vomiting			
Abdominal pain/tenderness			
*Mucosal bleeding			
Lethargy, restlessness			
Liver enlargement >2cm			
Pleural or abdominal effusion			
Additional Symptoms			
Diarrhea			
Cough			
Conjunctivitis			
Nasal congestion			
Sore throat			
Jaundice			
Convulsion or coma			
Nausea and vomiting (occasional)			
*Arthritis (swollen joints)			
*Missed school/work due to this illness			
*Unable to walk during this illness			

Information collected is confidential pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and reports will be maintained by the US Virgin Islands Department of Health.