



**Government of the District of Columbia
Department of Health
Communicable Disease Report Form**



Division of Epidemiology-Disease Surveillance & Investigation (DE-DSI)
Office of the Director

Investigation ID: _____
MMWR Wk: _____ Year _____
THIS BOX FOR DC DOH USE ONLY

Final Dx: _____
 Confirmed Probable Suspect Transfer Not a case
THIS BOX FOR DC DOH USE ONLY

NOTE: This form should be used for all reportable conditions EXCEPT the following: HIV, Tuberculosis, Hepatitis, and STDs

Clinical/Suspected Diagnosis: _____

Submitted by: _____ Date: _____

*Affiliation/Organization: _____ Hospital Laboratory Clinic

PATIENT INFORMATION

*Last Name: _____ *First Name: _____ MRN: _____

Address: _____ *City: _____ *State: _____ *Zip: _____

*Birth Date: _____ *Home Phone: _____ Work Phone: _____ Other Phone: _____

Occupation: _____ Food Handler Child Caregiver Health care worker

School/Daycare Attends _____

*Race: Black White Asian/Pacific Islander Native American/Alaskan Unknown

Ethnicity: Hispanic Non-Hispanic Household contacts: names/ages: _____

If patient is a minor, name of Parent(s)/guardian(s): _____

CLINICAL INFORMATION Acute illness Chronic Illness Patient notified of lab result? Yes No

Date of visit: _____ Admitted? Yes No Discharge Date: _____

Name of health care provider patient seen by: _____

Past Medical History _____ Symptom onset date: _____

Symptoms: _____ Symptom Duration: _____

Referred to/Follow-up: _____

DIAGNOSTIC TEST

*Collection date	*Specimen Type	Test	Result Date	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Drug resistant: Yes[#] No Unknown/Not tested

[#]If Yes, resistant drugs: _____ (Please include the laboratory results with this form)

TREATMENT

Date Started	Drug	Dose	Route	Frequency	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Additional Comments: _____

Please Fax This Form to DE-DSI: (202) 442-8060



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Suspected Chikungunya Case

Patient's Health Care Provider: Name: _____
Tel: _____ **Email:** _____ **Fax:** _____

Person filling out form: Name: _____
Tel: _____ **Email:** _____ **Fax:** _____

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

	Yes	No	Don't know
Fever lasting 2-7 days			
Fever(>38°C/101F)			
Platelets ≤ 100,000/mm ³			
Platelet count: _____			
Petechiae			
Purpura/Ecchymosis			
Vomit with blood			
Blood in stool			
Nasal bleeding			
Bleeding gums			
Blood in urine			
Vaginal bleeding			
Positive urinalysis (over 5RBC/hpf or positive for blood)			

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) _____

<u>Symptoms</u>	<u>Yes</u>	<u>No</u>	<u>Unk</u>
Rapid, weak pulse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pallor or cool skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body (muscle/bone) pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Warning signs

	<u>Yes</u>	<u>No</u>	<u>Unk</u>
Persistent vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain/tenderness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucosal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy, restlessness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver enlargement >2cm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleural or abdominal effusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional symptoms

	<u>Yes</u>	<u>No</u>	<u>Unk</u>
Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsion or coma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea and vomiting (occasional).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (swollen joints).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missed school/work due to this illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to walk during this illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Pregnancy at time of exposure? Yes No

If yes how far along is the pregnancy? _____

Travel Information:

Traveled outside of the continental U.S.? Yes No

Date left U.S.: _____

Destination/Places visited: _____

Date returned to U.S.: _____

Person(s) traveling with patient _____

Symptom onset date of person traveling with patient (if applicable):

Symptoms of person traveling with patient (if applicable):

Any other sick contacts in patient's household that were not traveling? Yes No

Names _____ Age _____

Relationship to patient _____

Other pertinent information not already listed (if applicable): _____