

NJDOH DENGUE INVESTIGATION WORKSHEET

CDRSS #: _____

DEMOGRAPHICS

Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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Occupation: _____	Pregnancy status <input type="checkbox"/> Pregnant <input type="checkbox"/> Not pregnant <input type="checkbox"/> N/A <input type="checkbox"/> Unknown
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CLINICAL INFORMATION

Date first seen by a medical professional: ____ / ____ / ____	Onset Date (mm/dd/yy) ____ / ____ / ____	Diagnosis:
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General signs and symptoms:		Warning signs for severe dengue:	
<input type="checkbox"/> Fever Temp: _____ F	<input type="checkbox"/> Rash. Describe: _____	<input type="checkbox"/> Abdominal pain/tenderness	<input type="checkbox"/> Liver enlargement (>2cm)
<input type="checkbox"/> Headache	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Persistent vomiting	<input type="checkbox"/> Extravascular fluid accumulation (pleural or pericardial effusion, ascites)
<input type="checkbox"/> Pain behind eyes	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Mucosal bleeding	<input type="checkbox"/> Increasing hematocrit concurrent with rapid decrease in platelet count
<input type="checkbox"/> Joint pain (arthralgia)	<input type="checkbox"/> Other, specify: _____	Site(s): _____	
<input type="checkbox"/> Muscle pains (myalgia)			

Severe dengue symptoms:			
<input type="checkbox"/> Severe plasma leakage defined by:	<input type="checkbox"/> Severe GI tract bleeding	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other organ involvement. Specify: _____
<input type="checkbox"/> a) Hypovolemic shock	<input type="checkbox"/> Severe vaginal bleeding	<input type="checkbox"/> Encephalitis, meningitis, or encephalopathy, specify: _____	
<input type="checkbox"/> b) Extravascular fluid accumulation) with respiratory distress	<input type="checkbox"/> Treatment with IV fluids or blood transfusion	<input type="checkbox"/> Myocarditis or other cardiac syndrome	<input type="checkbox"/> Other, specify: _____

Was patient hospitalized because of this illness? <input type="checkbox"/> Yes, <i>specify location and date(s)</i> Hospital name: _____ Admission: ____ / ____ / ____ Discharge: ____ / ____ / ____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient die because of this illness? <input type="checkbox"/> Yes, Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Was patient previously diagnosed with Dengue? <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient vaccinated against Yellow Fever? <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient vaccinated against Japanese Encephalitis? <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unk
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LABORATORY TESTING

Platelet count _____ (L / McL) WBC count _____ (L / McL)	Hematocrit (%) _____ Elevated liver enzymes (U/L) ALTs _____ ASTs _____	Tourniquet test <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not performed
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RISK FACTORS

Was there travel to or relocation from a dengue endemic areas in the 3 weeks prior to onset? <input type="checkbox"/> Yes Dates: ____ / ____ / ____ - ____ / ____ / ____ Location: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient recently donate blood or organs? <input type="checkbox"/> Yes Date: ____ / ____ / ____ Location of donation: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Did the patient receive a blood transfusion in the past 30 days? (If yes, specify)	Did the patient receive an organ transplant in the past 30 days? (If yes, specify)
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