**Utah Public Health**

**Name of Local Health Department**

**Address of Local Health Department**

*Phone:* ***(801) xxx-xxxx*** *Confidential Fax* ***(801) xxx-xxxx***

**CONFIDENTIAL CASE**

**REPORT**

**Yellow Fever Investigation Form**

***Yellow fevers is an urgently reportable disease***

**DEMOGRAPHIC INFORMATION**

Address: City: State:

County: Zip: Date of birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age:

Last Name: First Name: MI:

Phone #1: Phone #2: Phone #3:

Gender: *(Circle one)* Race: *(Check all that apply)*

M F *□* White *□* Black/African American *□* American Indian *□* Unknown

*□* Asian *□* Alaskan Native *□* Native Hawaiian or Pacific Islander

Ethnicity: *□* Hispanic *□* Not Hispanic *□* Other *□* Unknown

Parent/guardian name: Relationship:

Patient’s occupation:

**CLINICAL INFORMATION**

Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Clinician name: Clinician phone #:

Was patient hospitalized? Y N U Hospital:

Date of admission: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Medical record #:

Did patient die? Y N U Date of death: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

***`***

Is patient*:*

Pregnant Y N U

Breastfeeding Y N U

Being breastfed Y N U

Infection presentation (*Check only one):* □ Asymptomatic □ Febrile Illness □ Neuroinvasive disease □ Unknown □ Other

If **other** than list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **neuroinvasive** then *(Check all that apply)*: □ Meningitis □ Encephalitis □ Meningoencephalitis

□ Acute flaccid paralysis

If **asymptomatic** then: Was patient a blood donor? Y N U

Was treatment given? □ Yes □ No □ Unknown

If yes, provide the following information:

Treatment Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment Stop Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quantity\_\_\_\_\_\_\_\_\_\_\_

Did the patient have CSF pleocytosis? □ Yes □ No □ Unknown

Was serology (IgG - convalescent) done? Y N U

Name of laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Serology value: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test results: *(Check one)*

□ Positive - Confirmed □ Inconclusive □ Negative □ Pending

Was serology (IgM – convalescent) done? Y N U

Name of laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Serology value: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test results: *(Check one)*

□ Positive - Confirmed □ Inconclusive □ Negative □ Pending

Was serology (IgG – acute) done? Y N U

Name of laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Serology value: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test results: *(Check one)*

□ Positive - Confirmed □ Inconclusive □ Negative □ Pending

Was serology (IgM – acute) done? Y N U

Name of laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Serology value: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test results: *(Check one)*

□ Positive - Confirmed □ Inconclusive □ Negative □ Pending

Was PRNT done? Y N U

Name of laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Test results: *(Check one)*

□ Positive - Confirmed □ Inconclusive □ Negative □ Pending

Was PCR done? Y N U

Name of laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Test results: *(Check one)*

□ Positive - Confirmed □ Inconclusive □ Negative □ Pending

**LABORATORY INFORMATION**

Has patient ever received*:*

Yellow fever vaccine Y N U

Japanese encephalitis vaccine Y N U

Tick-borne encephalitis vaccine Y N U

Has patient ever had:

Dengue Y N U

Powasson Y N U

Yellow fever Y N U

Japanese encephalitis virus Y N U

St. Louis encephalitis Y N U

**EXPOSURE HISTORY**

Date 2 weeks prior to onset: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

During the above period, has the patient seen mosquitos or standing water at home? Y N U

During the above period, has the patient seen mosquitoes or standing water at work? Y N U

During the exposure period, has the patient traveled outside of Utah? Y N U

If yes, what the date and location of travel? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date 4 weeks prior to onset: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

In past 4 weeks prior to symptom onset, has patient*:*

Received a blood transfusion Y N U

Donated blood or blood products Y N U

Received an organ transplant Y N U

Donated organ or tissues Y N U

Received a bloodborne exposure (e.g., needlestick) Y N U

**BIOTERRORISM**

*Answer the questions in the bioterrorism section ONLY if the patient was diagnosed with SLE, Dengue, or Yellow Fever.*

*DO NOT answer questions in this section if patient was diagnosed with West Nile virus.*

Did this patient have an appropriate exposure history for this disease? Y N U

Is this patient an appropriate age for this disease? Y N U

Is this an appropriate time of year for this disease? Y N U

Are the symptoms appropriate for this disease? Y N U

Was the patient previously healthy? Y N U

Is the patient responding to therapy? Y N U

According to wildlife resources, is there a concurrent outbreak known Y N U  
occurring in animals?

Does patient work in or with (select all that apply):

□ Healthcare □ Government □ Media (broadcast or print) □ Research laboratory □ Animals

If yes, provide additional information (place of employment, address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REPORTING**

Reported by: *(Check all that apply)*

□ Hospital/ICP □ Clinic/doctor’s office □ Lab □ General public □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_

What is the date the lab reported to the clinician? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Reporter’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reporter’s agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date reported to public health: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

LHD Investigator: Phone: Date submitted to UDOH: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

LHD Reviewer:

LHD Case Classification: *(Check one)*

*□* Confirmed □ Probable □ Suspect □ Pending □ Out of state □ Not a case

UDOH Case Classification: *(Check one)*

*□* Confirmed □ Probable □ Suspect □ Pending □ Out of state □ Not a case

Case classification: *(Check one)*

*□* Confirmed □ Probable □ Suspect □ Pending □ Out of state □ Not a case

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