CASE REPORT FORM

Arboviral Disease

EpiSurv No.

Disease Name

Reporting Authority

Name of Public Health Officer responsible for case

Notifier Identification

Reporting source* ○ General Practitioner ○ Hospital-based Practitioner ○ Laboratory ○ Self-notification ○ Outbreak Investigation ○ Other

Name of reporting source **Organisation**

Date reported* **Laboratory sample date** **Contact phone**

Usual GP **Practice** **GP phone**

GP/Practice address Number Street Suburb Town/City Post Code ☐ GeoCode

Case Identification

Name of case* Surname Given Name(s)

NHI number* **Email**

Current address* Number Street Suburb Town/City Post Code ☐ GeoCode

Phone (home) **Phone (work)** **Phone (other)**

Case Demography

Location **TA*** **DHB***

Date of birth* **OR** **Age** ○ Days ○ Months ○ Years

Sex* ○ Male ○ Female ○ Unknown ○ Other

Occupation*

Occupation location ○ Place of Work ○ School ○ Pre-school

Name

Address Number Street Suburb Town/City Post Code ☐ GeoCode

Alternative location ○ Place of Work ○ School ○ Pre-school

Name

Address Number Street Suburb Town/City Post Code ☐ GeoCode

Ethnic group case belongs to* (tick all that apply)

☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori

☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan

☐ Other (such as Dutch, Japanese, Tokelauan) *(specify)

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Basis of Diagnosis

CLINICAL CRITERIA

Fits Clinical Description* ○ Yes ○ No ○ Unknown

Clinical features

Main clinical syndrome (tick appropriate options(s))

- ☐ Encephalitis: acute central nervous system disease with aseptic meningitis or encephalitis
- ☐ Fever with or without an exanthem
- ☐ Arthritis and rash

Clinical comments

LABORATORY CRITERIA

Meets laboratory criteria for disease*	○ Yes	○ No	○ Not Done	○ Awaiting Results
If yes, specify method of laboratory confirmation (tick all that apply)				
Detection of arbovirus nucleic acid (NAAT)	○ Yes	○ No	○ Not Done	○ Awaiting Results
IgG seroconversion	○ Yes	○ No	○ Not Done	○ Awaiting Results
Significant rise in IgG antibody level	○ Yes	○ No	○ Not Done	○ Awaiting Results
Detection of NS-1 antigen (dengue fever only)	○ Yes	○ No	○ Not Done	○ Awaiting Results
Positive IgM antibody (laboratory suggestive evidence)	○ Yes	○ No	○ Not Done	○ Awaiting Results
Other positive test (specify)				

CLASSIFICATION* ○ Under investigation ○ Probable ○ Confirmed ○ Not a case

ADDITIONAL LABORATORY DETAILS

Serotype*

If dengue, is there evidence of a previous dengue infection?* ○ Yes ○ No ○ Unknown

Clinical Course and Outcome

Date of onset* ☐ Approximate ☐ Unknown

Hospitalised* ○ Yes ○ No ○ Unknown

Date hospitalised* ☐ Unknown

Hospital*

Died* ○ Yes ○ No ○ Unknown

Date died* ☐ Unknown

Was this disease the primary cause of death?* ○ Yes ○ No ○ Unknown

If no, specify the primary cause of death*

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*

☐ Yes **If yes, specify Outbreak No.***

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Risk Factors

Was the case overseas during the incubation period for this disease?* ○ Yes ○ No ○ Unknown

If yes, date arrived in New Zealand*

Specify countries visited* (from most recent to least recent)

	Country/Region*	Date Entered*	Date Departed*
Last:*			
Second Last:*			
Third Last:*			

Country where arboviral disease probably acquired*

Specify location(s) visited (e.g. village, resort, island, region)

If the case has not been overseas recently, is there any prior history of overseas travel that might account for this infection?* ○ Yes ○ No ○ Unknown

If yes, give details of travel*

Did the case travel within New Zealand during the 15 days before becoming ill?* ○ Yes ○ No ○ Unknown

Specify where in NZ the case travelled*

Does the case's occupation involve contact with imported goods (e.g. imported machinery, tyres)?* ○ Yes ○ No ○ Unknown

Other risk factors for disease*

Protective Factors

Prior to onset, had the case been immunised with appropriate vaccine?* ○ Yes ○ No ○ NA ○ Unknown

If yes, specify date of last vaccination* ☐ Unknown

If yes, specify how vaccination status was confirmed?* ○ Patient/caregiver recall ○ Documented

Did the case take any of the following precautions:*

Use of insect repellents*	○ Always	○ Occasionally	○ Rarely	○ Never
Use of bed nets*	○ Always	○ Occasionally	○ Rarely	○ Never
Screened/air conditioned accommodation*	○ Always	○ Occasionally	○ Rarely	○ Never
Wearing of long sleeved shirts and trousers*	○ Always	○ Occasionally	○ Rarely	○ Never
Any other precautions against biting insects*	○ Always	○ Occasionally	○ Rarely	○ Never

Specify*

Management

Is the case pregnant (Zika only) ○ Yes ○ No ○ NA ○ Unknown

If Yes: gestation at time of onset of symptoms weeks

or if asymptomatic, gestation at time sample collected weeks

Comments*