MDH Minnesota Department of Health
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ARBOVIRAL DISEASE CASE REPORT FORM (Endemic to North America)

DISEASE ETIOLOGY

	Conf	Prob	Susp	Not case	Asymptomatic Donor	Neuro	Non-neuro
☐ West Nile virus (WNV)	○	○	○	○	☐	☐	☐
☐ Powassan virus (POWV)	○	○	○	○	☐	☐	☐
☐ La Crosse encephalitis virus (LACV)	○	○	○	○	☐	☐	☐
☐ Jamestown Canyon virus (JCV)	○	○	○	○	☐	☐	☐
☐ Western equine encephalitis virus (WEEV)	○	○	○	○	☐	☐	☐
☐ Eastern equine encephalitis virus (EEEV)	○	○	○	○	☐	☐	☐
☐ St Louis encephalitis virus (SLE)	○	○	○	○	☐	☐	☐
☐ Other:	○	○	○	○	☐	☐	☐

ArboNET ID:

MEDSS ID:

Reported by:
☐ Lab: ☐ ELR ☐ Paper
☐ ICP (IP)
☐ Provider
☐ Other: ___________

Task Staff Date
☐CRF
☐Entry
☐Rev

ONSET DATE: ______ /______ /__________ ☐ Date unknown

Reporting Date: ______ /______ /_________

DEMOGRAPHICS

NAME: *(Last)* ________________________ *(First)* ____________________ *(Middle)* _____ Parent/Guardian: ________________

DOB: ______ /______ /_________ Age: ______ SEX: ☐ M ☐ F ☐ Unk

PHONE:

ADDRESS: *(Street)* ______________________________________

(______) -________-__________ (h)

(City) ____________________ *(State)* ______ *(Zip)* _________ COUNTY: ______________

(______) -________-__________(c/w)

Race: ☐Unk ☐American Indian/ Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/ Pacific Islander ☐White ☐Other:

Ethnicity: ☐Unk ☐Hispanic/Latino ☐Non-Hispanic/Latino

HOSPITAL/CLINIC INFORMATION

REPORTER:
Name: ______________________________ ☐ Same as provider
Role: ☐Provider ☐ICP (IP) ☐Lab ☐Unk ☐ Other:
Facility: ____________________ Ph: (______) -________-_________

PROVIDER:
Name: ______________________________
Facility: ______________________ Ph: (______) -________-_________

	Yes	No	Unk	
Hospitalized?	☐	☐	☐	Admit date: _____/_____ /_______ Discharge date: _____ /_____ /_______ Hospital: ______________
Pregnant?	☐	☐	☐	
Died?	☐	☐	☐	Date of death: _____/_____ /_______ Cause of death: ____________________ Related to arboviral infection? ☐Y ☐N ☐U

HEALTH HISTORY

	Yes	No	Unk	
Immune suppression?	☐	☐	☐	*If yes:* ☐ Cancer ☐ Diabetes ☐ Medication* ☐ Other: ____________________
Underlying illness ?	☐	☐	☐	Describe: ____________________
Transfusion or transplant <30 days before onset?	☐	☐	☐	Dates, product/s, location, reason:

* Includes corticosteroids, radiation, alkylating drugs, antimetabolites, TNF-alpha inhibitors, or other antibodies targeting immune cells

CLINICAL INFORMATION

	Yes	No	Unk	
SYMPTOMATIC?	☐	☐	☐	Onset date: *record on top of form.*
More likely clinical explanation than arboviral disease?	☐	☐	☐	Describe:

Clinical info is from office date(s): ____/____ /______

	Yes	No	Unk	
FEVER (subjective or measured)	☐	☐	☐	Max temperature: _________ ° F (☐ unknown)
Any fever reducing medication?	☐	☐	☐	(asprin, Tylenol, ibuprofen)

SIGNS/SYMPTOMS	Yes	No	Unk	
Chills/rigors	☐	☐	☐	
Headache	☐	☐	☐	
Stiff neck	☐	☐	☐	
Myalgia *(muscle aches)*	☐	☐	☐	
Arthralgia *(joint pain)*	☐	☐	☐	
Nausea/vomiting	☐	☐	☐	
Fatigue/malaise	☐	☐	☐	
Rash	☐	☐	☐	
Other signs/symptoms	☐	☐	☐	*Describe (optional):*
Any complications?	☐	☐	☐	*Describe:* ☐ Myocarditis ☐ Pancreatitis ☐ Hepatitis ☐ Ocular (chorioretinitis, iridocyclitis) ☐ Other:

NEUROINVASIVE DISEASE	Yes	No	Unk
Aseptic meningitis	☐	☐	☐
Encephalitis	☐	☐	☐
Acute flaccid paralysis	☐	☐	☐
Other acute signs of central/ peripheral neurologic dysfunction (documented by physician)	☐	☐	☐

Neuroinvasive details: *(mark all that apply)*
☐ Disorientation ☐ Obtundation ☐ Ataxia ☐ Stupor ☐ Coma ☐ Other:
☐ Nerve palsies ☐ Paresis ☐ Sensory deficit ☐ Paralysis ☐ Hypokinesia
☐ Abnormal reflexes ☐ Abnormal movements ☐ Altered mental status ☐ Convulsions ☐ Seizure

	Yes	No	Unk	
CSF collected?	☐	☐	☐	Date: ______ / ______ / ________ WBC: ______ (lymphs: _____%) RBC: ______ Glucose: ______ Protein: _______
Neuroimaging?	☐	☐	☐	Date: ______ / ______ / ________ ☐MRI ☐CT Result: ☐Normal ☐Abnormal Describe: ______________

SERUM TESTING

	Assay	Collection Date	Lab Name	Virus	IgM Pos	IgM Neg	IgM Titer/OD	IgM Unk	IgM ND	IgG Pos	IgG Neg	IgG Titer/OD	IgG Unk	IgG ND
ACUTE serum antibody ☐not done		_____ / _____ /_______		WNV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				POW	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				LACV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				JCV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				WEEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				EEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				SLEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
CONVALESCENT serum antibody ☐not done		_____ / _____ /_______		WNV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				POW	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				LACV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				JCV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				WEEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				EEEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				SLEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
PCR/Molecular (including NAT) ☐not done		_____ / _____ /_______		WNV	☐	☐		☐	☐					
				LACV	☐	☐		☐	☐					
				POW	☐	☐		☐	☐					
				JCV	☐	☐		☐	☐					
				WEEV	☐	☐		☐	☐					
				EEEV	☐	☐		☐	☐					
				SLEV	☐	☐		☐	☐					
				Flavivirus	☐	☐		☐	☐					

CSF TESTING

	Assay	Collection Date	Lab Name	Virus	IgM Pos	IgM Neg	IgM Titer/OD	IgM Unk	IgM ND	IgG Pos	IgG Neg	IgG Titer/OD	IgG Unk	IgG ND
ACUTE CSF antibody ☐not done		_____ / _____ /_______		WNV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				LACV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				POW	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				JCV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				WEEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				EEEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				SLEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
CONVALESCENT CSF antibody ☐not done		_____ / _____ /_______		WNV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				LACV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				POW	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				JCV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				WEEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				EEEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
				SLEV	☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
PCR/Molecular ☐not done		_____ / _____ /_______		WNV	☐	☐		☐	☐					
				LACV	☐	☐		☐	☐					
				POW	☐	☐		☐	☐					
				JCV	☐	☐		☐	☐					
				WEEV	☐	☐		☐	☐					
				EEEV	☐	☐		☐	☐					
				SLEV	☐	☐		☐	☐					
				Flavivirus	☐	☐		☐	☐					

CONFIRMATORY TESTING

	Assay	Source	Collection Date	Lab Name	Virus	IgM RESULT Pos	Neg	Titer/OD	Unk	ND	IgG RESULT Pos	Neg	Titer/OD	Unk	ND
ELISA/EIA, IFA, or MIA ☐not done		☐Serum ☐CSF ☐Other	_____ / _____ /______			☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
						☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
						☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
						☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
						☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
						☐	☐	_________	☐	☐	☐	☐	_________	☐	☐
PRNT ☐not done		☐Serum ☐CSF ☐Other	_____ / _____ /______			☐	☐	_________	☐	☐					
						☐	☐	_________	☐	☐					
						☐	☐	_________	☐	☐					
						☐	☐	_________	☐	☐					
						☐	☐	_________	☐	☐					
						☐	☐	_________	☐	☐					
Molecular (PCR, NAT, sequencing) ☐not done		☐Serum ☐CSF ☐Other	_____ / _____ /______			☐	☐		☐	☐					
						☐	☐		☐	☐					
						☐	☐		☐	☐					
						☐	☐		☐	☐					
						☐	☐		☐	☐					
						☐	☐		☐	☐					
						☐	☐		☐	☐					

EXPOSURE HISTORY

In the month prior to illness onset, did this patient...

	Yes	No	Unk
• Travel outside county of residence?	☐	☐	☐
• Have a known exposure to disease vector?	☐	☐	☐
• Have a known laboratory exposure?	☐	☐	☐
• Perinatal or breastfeeding exposure? (infants only)	☐	☐	☐

If yes to any, please describe: