North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

DENGUE
Confidential Communicable Disease Report—Part 2

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date(mm/dd/yyyy): ____/____/____
Was the fever recurring, remittent, or intermittent? ☐Y ☐N ☐U
Headache ☐Y ☐N ☐U
Joint pains (arthralgias) ☐Y ☐N ☐U
Muscle aches / pains (myalgias) ☐Y ☐N ☐U
Skin rash ☐Y ☐N ☐U
Eye pain ☐Y ☐N ☐U
Hemorrhagic symptoms/signs ☐Y ☐N ☐U
Specify (check all that apply):
☐ Petechiae
☐ Ecchymosis
☐ Purpura
☐ Nasal bleeding (epistaxis)
☐ Gingival bleeding
☐ Vomiting blood (hematemesis)
☐ Frank blood in stool
☐ Blood in urine (hematuria, i.e., urinalysis >5 RBC/hpf or positive for blood)
☐ Vaginal bleeding
☐ Melena
☐ Other

CLINICAL FINDINGS

Chills or rigors ☐Y ☐N ☐U
Altered mental status ☐Y ☐N ☐U
Patient displayed (check all that apply):
☐ Confusion ☐ Disorientation ☐ Coma
Seizures/convulsions ☐Y ☐N ☐U
Specify:
☐ New onset
☐ Exacerbation of underlying seizure disorder
☐ Other, specify:_____
Conjunctivitis ☐Y ☐N ☐U
Nasal congestion ☐Y ☐N ☐U
Hemorrhage-subungual and retinal (trich) ☐Y ☐N ☐U
Sore throat ☐Y ☐N ☐U
Cough ☐Y ☐N ☐U
Hemorrhagic pleural effusion ☐Y ☐N ☐U
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Diarrhea ☐Y ☐N ☐U
Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia) ☐Y ☐N ☐U
Ascites (abdominal effusion) ☐Y ☐N ☐U
Thrombocytopenia ☐Y ☐N ☐U
Elevated hematocrit? ☐Y ☐N ☐U
Hypotension ☐Y ☐N ☐U
Lowest BP: _____
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
Specify:

PREGNANCY

Is the patient currently pregnant? ☐Y ☐N ☐U
Estimated delivery date_____
Is patient a post-partum mother (≤6 weeks)**?** ☐Y ☐N ☐U

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

_____

Survived? ☐ Y ☐ N ☐ U
Died? ☐ Y ☐ N ☐ U
Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): ____/____/____

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 14 days prior to onset of symptoms, did the patient have the following health care exposure?

☐ **Transplant recipient** (tissue/organ/bone/bone marrow)

Date received (mm/dd/yyyy): _____
Type of donation/transplant _____
Provider name _____
Facility name _____
Contact name at facility _____
Address _____
City _____ State _____
Country _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U
Date of interview (mm/dd/yyyy): ____/____/____
Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U
Specify reason if medical records were not reviewed:

Notes on medical record verification:

TRAVEL/IMMIGRATION

The patient is:
☐ Resident of NC
☐ Resident of another state or US territory
☐ Foreign Visitor
☐ Refugee
☐ Recent Immigrant
☐ Foreign Adoptee
☐ None of the above

Did patient have a travel history during the 14 days prior to onset of symptoms? ☐ Y ☐ N ☐ U

List travel dates and destinations _____

_____

_____

Additional travel/residency information:

VECTOR EXPOSURES

During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to mosquitoes ☐ Y ☐ N ☐ U

Exposed on(mm/dd/yyyy): ____/____/____
Until(mm/dd/yyyy): ____/____/____
Frequency:
☐ Once
☐ Multiple times within this time period
☐ Daily

City/county of exposure _____
State of exposure _____
Country of exposure _____

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:
☐ In NC
City _____
County _____
☐ Outside NC, but within US
City _____
State _____
County _____
☐ Outside US
City _____
Country _____
☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes:

VACCINE

Has patient ever received vaccine related to this disease? ☐ Y ☐ N ☐ U

Vaccine type _____
☐ Unknown vaccine or immune globulin
Date of administration (mm/dd/yyyy): ____/____/____
Source of this vaccine information _____

_____

How many days prior to illness onset was vaccine received?
☐ Fewer than 14 days
☐ 14 days or more
Vaccine date unknown ☐ Yes ☐ No