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

North Carolina Public Health

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

YELLOW FEVER
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
Hepatitis (inflamed liver) ☐Y ☐N ☐U
Etiology: ☐ Viral ☐ Non-viral ☐ Unknown
Albuminuria ☐Y ☐N ☐U

CLINICAL FINDINGS

Pulse-temperature dissociation ☐Y ☐N ☐U
Chills or rigors ☐Y ☐N ☐U
Prostration ☐Y ☐N ☐U
Shock ☐Y ☐N ☐U
Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia) ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____
Acute liver failure ☐Y ☐N ☐U
Acute renal failure ☐Y ☐N ☐U
Leukopenia ☐Y ☐N ☐U
Hemorrhagic symptoms/signs ☐Y ☐N ☐U
Specify (check all that apply):
☐ Petechiae
☐ Ecchymosis
☐ Purpura
☐ Conjunctival hemorrhage
☐ 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
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
Has the patient been pregnant in the past 12 months? ☐Y ☐N ☐U
Did patient experience onset of symptoms within 6 weeks of delivery? ☐Y ☐N ☐U

MATERNAL INFORMATION

Was the child breastfed? ☐Y ☐N ☐U
Did the biologic mother ever have evidence of serological IgG immunity? ☐Y ☐N ☐U
Test date: ____/____/____
Result:
☐ Positive ☐ Negative ☐ Equivocal ☐ Unk.

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):_____/_____/_____

VECTOR EXPOSURE

During the 14 days prior to onset, 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

County of exposure _____

State of exposure _____

Country of exposure _____

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? ☐ Y ☐ N ☐ U

List travel dates and destinations:

From _____/_____/_____ to _____/_____/_____

_____

_____

_____

Additional travel/residency information:

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

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: