

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

DENGUE / SEVERE DENGUE CASE REPORT

Check one: Dengue
 Severe Dengue

Please note: Prompt, standardized interview of all cases of dengue is strongly encouraged to improve the accuracy of recall of possible sources of infection. Jurisdictions that choose to use this form should send completed forms to the Surveillance and Statistics Section through your communicable disease reporting staff. For jurisdictions participating in CalREDIE, entry of information into the CalREDIE form will facilitate investigations and surveillance.

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street – Residence			Apartment / Unit Number		Ethnicity (check one)
City / Town		State	Zip Code		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown
Census Tract	County of Residence		Country of Residence		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone / Pager		Work / School Telephone	
E-mail Address			Other Electronic Contact Information		
Work / School Location			Work / School Contact		
Gender <input type="checkbox"/> Female <input type="checkbox"/> Trans female / transwoman <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Trans male/ transman <input type="checkbox"/> Identity not listed <input type="checkbox"/> Declined to answer					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes, Est. Delivery Date (mm/dd/yyyy)		
Medical Record Number			Patient's Parent/Guardian Name		
Occupation Setting (see list on page 7)			Other Describe/Specify		
Occupation (see list on page 7)			Other Describe/Specify		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply, see list on page 6) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Malaysian <input type="checkbox"/> Chinese <input type="checkbox"/> Pakistani <input type="checkbox"/> Filipino <input type="checkbox"/> Sri Lankan <input type="checkbox"/> Hmong <input type="checkbox"/> Taiwanese <input type="checkbox"/> Indonesian <input type="checkbox"/> Thai <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____ <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 6) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Fijian <input type="checkbox"/> Tongan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____ <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown					
ADDITIONAL PATIENT DEMOGRAPHICS					
Sex Assigned at Birth		Sexual Orientation			
<input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Declined to answer		<input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Questioning, unsure, or patient doesn't know <input type="checkbox"/> Declined to answer <input type="checkbox"/> Gay, lesbian, or same-gender loving <input type="checkbox"/> Orientation not listed <input type="checkbox"/> Unknown <input type="checkbox"/> Bisexual			

First three letters of
patient's last name:

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CLINICAL INFORMATION										
Physician Name - Last Name				First Name				Telephone Number		
SIGNS AND SYMPTOMS										
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Onset Date (mm/dd/yyyy)				Date First Sought Medical Care (mm/dd/yyyy)			
Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted	Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Fever				Highest temperature (specify °F/°C)	Purpura / Ecchymosis					
Headache					Abdominal pain					
Eye pain					Sweats					
Muscle pain					Epistaxis					
Joint pain				Joint(s)	Bleeding gums					
Nausea or vomiting					Hematuria					
Rash					Vaginal bleeding					
Diarrhea					Hypotension				Date measured (mm/dd/yyyy)	
Chills									Systolic / Diastolic	
Cough					Other symptom (specify)					
Petechiae										
PAST MEDICAL HISTORY										
Has the patient been previously diagnosed with dengue? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				If Yes, date of diagnosis (mm/dd/yyyy)				Serotype (if known) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
HOSPITALIZATION										
Did the patient visit the emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										
Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				If Yes, how many total hospital nights?				During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If there were any ER visits or hospital stays related to this illness, specify details in the Hospitalization – Details section below.										
HOSPITALIZATION – DETAILS										
Hospital Name 1		Street Address				Admit Date (mm/dd/yyyy)				
		City				Discharge / Transfer Date (mm/dd/yyyy)				
		State	Zip Code	Telephone Number		Medical Record Number		Discharge Diagnosis		
Hospital Name 2		Street Address				Admit Date (mm/dd/yyyy)				
		City				Discharge / Transfer Date (mm/dd/yyyy)				
		State	Zip Code	Telephone Number		Medical Record Number		Discharge Diagnosis		

First three letters of patient's last name:

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OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Other: _____	Laboratory Type <input type="checkbox"/> State PH lab <input type="checkbox"/> Local PH Lab <input type="checkbox"/> Commercial lab <input type="checkbox"/> CDC lab <input type="checkbox"/> Blood bank <input type="checkbox"/> Other (specify): _____		
	Type of Test <input type="checkbox"/> PCR <input type="checkbox"/> ELISA-IgM <input type="checkbox"/> ELISA-IgG <input type="checkbox"/> IFA-IgM <input type="checkbox"/> IFA-IgG <input type="checkbox"/> PRNT <input type="checkbox"/> Other (specify): _____		
	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	Results	Collection Date (mm/dd/yyyy)
	Laboratory Name		Telephone Number

Specimen Type 2 <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Other: _____	Laboratory Type <input type="checkbox"/> State PH lab <input type="checkbox"/> Local PH Lab <input type="checkbox"/> Commercial lab <input type="checkbox"/> CDC lab <input type="checkbox"/> Blood bank <input type="checkbox"/> Other (specify): _____		
	Type of Test <input type="checkbox"/> PCR <input type="checkbox"/> ELISA-IgM <input type="checkbox"/> ELISA-IgG <input type="checkbox"/> IFA-IgM <input type="checkbox"/> IFA-IgG <input type="checkbox"/> PRNT <input type="checkbox"/> Other (specify): _____		
	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	Results	Collection Date (mm/dd/yyyy)
	Laboratory Name		Telephone Number

LABORATORY RESULTS SUMMARY - OTHER

Hematology <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date Collected (mm/dd/yyyy)	WBC	HCT	Hb	Platelets
Other laboratory diagnostics performed (e.g., IHC, virus isolation)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes, describe			

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 14 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

Did patient travel outside of county of residence during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Has the patient traveled outside the U.S. during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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If Yes for either of these questions, specify all locations and dates below.

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					

First three letters of patient's last name:

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EXPOSURES / RISK FACTORS

Did patient recall any mosquito bites during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, specify all locations and dates below.
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MOSQUITO BITE HISTORY - DETAILS

Location (city, county, state, country)	Date of Mosquito Bite (mm/dd/yyyy)

NOTES / REMARKS

REPORTING AGENCY

<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			

DISEASE CASE CLASSIFICATION

Case Classification (see case on page 5)

Confirmed Probable Suspect

STATE USE ONLY

Case Classification

Confirmed Probable Suspect Not a case Need additional information

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CASE DEFINITION**DENGUE (CDPH, working definition 2015)***Dengue and Severe Dengue Symptomatic cases**(adapted from the 2015 CSTE case definition <https://ndc.services.cdc.gov/case-definitions/dengue-virus-infections-2015/>)***CLINICAL DESCRIPTION****Dengue**

Dengue is defined by fever as reported by the patient or healthcare provider and the presence of one or more of the following signs and symptoms:

- Nausea/vomiting
- Rash
- Aches and pains (e.g., headache, retro-orbital pain, joint pain, myalgia, arthralgia)
- Tourniquet test positive
- Leukopenia (a total white blood cell count of $<5,000/\text{mm}^3$), **OR**
- Any warning sign for severe dengue:
 - Abdominal pain or tenderness
 - Persistent vomiting
 - Extravascular fluid accumulation (e.g., pleural or pericardial effusion, ascites)
 - Mucosal bleeding at any site
 - Liver enlargement >2 centimeters
 - Increasing hematocrit concurrent with rapid decrease in platelet count.

Severe Dengue

Severe dengue is defined as dengue with any one or more of the following scenarios:

- Severe plasma leakage evidenced by hypovolemic shock and/or extravascular fluid accumulation (e.g., pleural or pericardial effusion, ascites) with respiratory distress. A high hematocrit value for patient age and sex offers further evidence of plasma leakage.
- Severe bleeding from the gastrointestinal tract (e.g., hematemesis, melena) or vagina (menorrhagia) as defined by requirement for medical intervention including intravenous fluid resuscitation or blood transfusion.
- Severe organ involvement, including any of the following:
 - Elevated liver transaminases: aspartate aminotransferase (AST) or alanine aminotransferase (ALT) $\geq 1,000$ per liter (U/L)
 - Impaired level of consciousness and/or diagnosis of encephalitis, encephalopathy, or meningitis
 - Heart or other organ involvement including myocarditis, cholecystitis, and pancreatitis.

LABORATORY CRITERIA FOR DIAGNOSIS**Confirmatory:**

- Detection of DENV nucleic acid in serum, plasma, blood, cerebrospinal fluid (CSF), other body fluid or tissue by validated reverse transcriptase-polymerase chain reaction (PCR), **OR**
- Detection of DENV antigens in tissue by a validated immunofluorescence or immunohistochemistry assay, **OR**
- Detection in serum or plasma of DENV NS1 antigen by a validated immunoassay; **OR**
- Cell culture isolation of DENV from a serum, plasma, or CSF specimen; **OR**
- Detection of IgM anti-DENV by validated immunoassay in a serum specimen or CSF in a person living in a dengue endemic or non-endemic area of the United States without evidence of other flavivirus transmission (e.g., WNV, SLEV, or recent vaccination against a flavivirus (e.g., YFV, JEV)); **OR**
- Detection of IgM anti-DENV in a serum specimen or CSF by validated immunoassay in a traveler returning from a dengue endemic area without ongoing transmission of another flavivirus (e.g., WNV, JEV, YFV), clinical evidence of co-infection with one of these flaviviruses, or recent vaccination against a flavivirus (e.g., YFV, JEV); **OR**
- IgM anti-DENV seroconversion by validated immunoassay in acute (i.e., collected <5 days of illness onset) and convalescent (i.e., collected >5 days after illness onset) serum specimens; **OR**
- IgG anti-DENV seroconversion or ≥ 4 -fold rise in titer by a validated immunoassay in serum specimens collected >2 weeks apart, and confirmed by a neutralization test (e.g., plaque reduction neutralization test) with a >4 -fold higher end point titer as compared to other flaviviruses tested.

Probable:

- Detection of IgM anti-DENV by validated immunoassay in a serum specimen or CSF in a person living in a dengue endemic or non-endemic area of the United States with evidence of other flavivirus transmission (e.g., WNV, SLEV), or recent vaccination against a flavivirus (e.g., YFV, JEV).
- Detection of IgM anti-DENV in a serum specimen or CSF by validated immunoassay in a traveler returning from a dengue endemic area with ongoing transmission of another flavivirus (e.g., WNV, JEV, YFV), clinical evidence of co-infection with one of these flaviviruses, or recent vaccination against a flavivirus (e.g., YFV, JEV).

Suspected:

- The absence of IgM anti-DENV by validated immunoassay in a serum or CSF specimen collected <5 days after illness onset and in which molecular diagnostic testing was not performed in a patient with an epidemiologic linkage.

(continued on page 6)

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CASE DEFINITION (continued)**EPIDEMIOLOGIC LINKAGE**

- Travel to a dengue endemic country or presence at location with ongoing outbreak within previous two weeks of onset of an acute febrile illness or dengue, **OR**
- Association in time and place (e.g., household member, family member, classmate, or neighbor) with a confirmed or probable dengue case.

CRITERIA TO DISTINGUISH A NEW CASE FROM AN EXISTING CASE

DENV infection results in long-lasting immunity to symptomatic infection (dengue) with that DENV-type. However, cross-protective (heterotypic) immunity is short-lived with estimated durations of 1-3 years. In dengue endemic areas where infection pressure is high, individuals have been shown to infrequently have sequential episodes of dengue with two different infecting serotypes.

Based on these data, a person with two clinical episodes of dengue occurring at least two weeks apart and shown to be due to different infecting DENV-types confirmed by molecular diagnostic testing would be classified as two different cases.

However, for two clinical episodes of dengue in the same person diagnosed only by IgM anti-DENV on the second episode; to be considered separate cases, they would have to occur >90 days apart due to the persistence of detectable IgM anti-DENV for ~90 days.

EXPOSURE

- During the two weeks prior to onset of fever, travel to a dengue endemic country or presence in a location experiencing an ongoing dengue outbreak, **OR**
- Association in time and place with a confirmed or probable dengue case.

ENDEMICITY

The largest burden of dengue in the United States is in the territories of Puerto Rico and the U.S. Virgin Islands where it is endemic. As such, the majority of reported dengue cases in the U.S. come from these two territories, where existing surveillance systems are in place to capture both the incidence and to some degree the spectrum of disease. Other areas of the US where dengue is or has been endemic include American Samoa, the Northern Marianas, and Guam. In addition, hundreds of travel-associated dengue cases occur each year, primarily in the 50 United States and the District of Columbia.

CASE CLASSIFICATION

Suspect: A clinically compatible case of dengue-like illness, dengue, or severe dengue with an epidemiologic linkage, as defined above.

Probable: A clinically compatible case of dengue-like illness, dengue, or severe dengue with laboratory results indicative of probable infection, as defined above.

Confirmed: A clinically compatible case of dengue-like illness, dengue, or severe dengue with confirmatory laboratory results, as defined above.

COMMENT

The 2009 CSTE Dengue Position Statement included the reporting of DENV-positive asymptomatic blood donors identified through pilot screening projects in dengue endemic areas. However, these screening projects have ended, no cases were reported, and the "Asymptomatic Blood or Tissue Donor" reporting category will be deleted, limiting reporting to persons with symptomatic DENV infection (i.e., dengue).

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

- | | | | | |
|---------------|--------------|--------------|---------------|--------------|
| • Bangladeshi | • Filipino | • Japanese | • Maldivian | • Sri Lankan |
| • Bhutanese | • Hmong | • Korean | • Nepalese | • Taiwanese |
| • Burmese | • Indian | • Laotian | • Okinawan | • Thai |
| • Cambodian | • Indonesian | • Madagascar | • Pakistani | • Vietnamese |
| • Chinese | • Iwo Jiman | • Malaysian | • Singaporean | |

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- | | | | | |
|--------------|--------------------|---------------------|--------------------|-------------|
| • Carolinian | • Kiribati | • Micronesian | • Pohnpeian | • Tahitian |
| • Chamorro | • Kosraean | • Native Hawaiian | • Polynesian | • Tokelauan |
| • Chuukese | • Mariana Islander | • New Hebrides | • Saipanese | • Tongan |
| • Fijian | • Marshallese | • Palauan | • Samoan | • Yapese |
| • Guamanian | • Melanesian | • Papua New Guinean | • Solomon Islander | |

First three letters of patient's last name:

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OCCUPATION SETTING

- | | |
|--|--|
| <ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other | <ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other |
|--|--|

OCCUPATION

- | | |
|--|--|
| <ul style="list-style-type: none"> • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - waiter or waitress • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker | <ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - registered nurse • Medical - other/unknown • Military - officer • Military - recruit or trainee • Protective service - police officer • Protective service - other • Professional, technical, or related profession • Retired • Sex worker • Student - preschool or kindergarten • Student - elementary or middle school • Student - high (secondary) school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high (secondary) school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Other • Refused • Unknown |
|--|--|