

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

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

CHIKUNGUNYA CASE REPORT

Please note: Prompt, standardized interview of all cases of chikungunya 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 by mail 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	
<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Other: _____	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	Ethnicity (check one)	
<input type="checkbox"/> Years		<input type="checkbox"/> Months		<input type="checkbox"/> Days	
Address Number & Street - Residence			Apartment/Unit Number		
City/Town			State	Zip Code	
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"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 6)		Other Describe/Specify			
Occupation (see list on page 6)		Other Describe/Specify			
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

- English
- Spanish
- Other: _____
- Ethnicity (check one)**
- Hispanic/Latino
- Non-Hispanic/Non-Latino
- Unk
- Race***
(check all that apply, race descriptions on page 6)
- African-American/Black
- American Indian or Alaska Native
- Asian (check all that apply)
 - Asian Indian
 - Japanese
 - Cambodian
 - Korean
 - Chinese
 - Laotian
 - Filipino
 - Thai
 - Hmong
 - Vietnamese
 - Other: _____
- Pacific Islander (check all that apply)
 - Native Hawaiian
 - Samoan
 - Guamanian
 - Other: _____
- White
- Other: _____
- Unk

*Comment: self-identity or self-reporting
 The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

First three letters of patient's last name:

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SIGNS AND SYMPTOMS

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		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)	Nausea or vomiting					
Headache					Diarrhea					
Eye pain					Chills					
Muscle ache					Cough					
Joint pain				Joint(s)	Abdominal pain					
Joint swelling					Fatigue					
Rash				Maculopapular? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other symptom (specify):					

PAST MEDICAL HISTORY

Has the patient been previously diagnosed with chikungunya? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, date of diagnosis (mm/dd/yyyy)		
Does the patient have a history of cardiovascular disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Diabetes? <input type="checkbox"/> Yes, Type ___ <input type="checkbox"/> No <input type="checkbox"/> Unk
Other significant history/exposures:				

HOSPITALIZATION

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, how many total hospital nights?	
Was patient placed in respiratory isolation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If there were any ER or hospital stays related to this illness, specify details below.			

HOSPITALIZATION - DETAILS

Hospital Name 1	Street Address			Admission 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			Admission Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk		If Survived, Survived as of _____ (mm/dd/yyyy)		Date of Death (mm/dd/yyyy)
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First three letters of patient's last name:

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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Other: _____	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"/> 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: _____	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"/> 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"/> Unk	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"/> Unk			If Yes, describe		

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: UP TO 12 DAYS BEFORE ILLNESS ONSET

BLOOD AND ORGAN DONATION

Did patient donate blood during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___	Did patient donate an organ during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___
Did patient receive a blood transfusion during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___	Did patient receive an organ transplant during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___

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"/> Unk	Has the patient traveled outside of California during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Has the patient traveled outside the U.S. during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes for any of these questions, specify all locations and dates below.

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

EXPOSURES / RISK FACTORS

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

First three letters of
patient's last name:

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Location (city, county, state, country)		Date Mosquito Bite (mm/dd/yyyy)	
NOTES / REMARKS			
REPORTING AGENCY			
Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			
DISEASE CASE CLASSIFICATION			
Case Classification (see case definition below) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected			
STATE USE ONLY			
Case Classification <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information			
CASE DEFINITION			
<u>CHIKUNGUNYA (CDPH, working definition 2015)</u>			
CLINICAL DESCRIPTION			
Chikungunya is most often characterized by acute onset of fever (typically >39°C [102°F]) and polyarthralgia. Joint symptoms are usually bilateral and symmetric, and can be severe and debilitating. Other symptoms may include headache, myalgia, arthritis, conjunctivitis, nausea/vomiting, or maculopapular rash. Clinical laboratory findings can include lymphopenia, thrombocytopenia, elevated creatinine, and elevated hepatic transaminases. Acute symptoms typically resolve within 7–10 days. Rare complications include uveitis, retinitis, myocarditis, hepatitis, nephritis, bullous skin lesions, hemorrhage, meningoencephalitis, myelitis, Guillain-Barré syndrome, and cranial nerve palsies. Some patients might have relapse of rheumatologic symptoms (e.g., polyarthralgia, polyarthritis, tenosynovitis) in the months following acute illness. The majority of people infected with chikungunya virus become symptomatic. The incubation period is typically 3–7 days (range, 1–12 days).			
LABORATORY CRITERIA FOR DIAGNOSIS			
Confirmatory:			
<ul style="list-style-type: none"> • Isolation of chikungunya virus from or demonstration of specific arboviral or genomic sequences in tissue, blood, cerebrospinal fluid (CSF), or other body fluid by polymerase chain reaction (PCR) test (≤5 days after illness onset), immunofluorescence or immunohistochemistry, OR • Demonstration of a > 4-fold rise in reciprocal Immunoglobulin G (IgG) antibody titer or Hemagglutination inhibition titer to chikungunya virus antigens in paired acute and convalescent serum samples, OR 			

(continued on page 5)

First three letters of
patient's last name:

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CASE DEFINITION (continued)

- Demonstration of a > 4-fold rise in PRNT (Plaque reduction neutralization test) end point titer (as expressed by the reciprocal of the last serum dilution showing a 90% reduction in plaque counts compared to the virus infected control) between chikungunya virus and other arboviruses tested in a convalescent serum sample.

Presumptive/Probable:

- A positive chikungunya-specific Enzyme-linked immunosorbent assay (ELISA) or immunofluorescence assay (IFA) for immunoglobulin (Ig) M on a single acute or convalescent phase serum specimen.

EXPOSURE

- Travel to a chikungunya endemic country or presence at location with ongoing outbreak with previous two weeks of chikungunya-like illness, OR
- Association in time and place with a confirmed or probable chikungunya case.

CASE CLASSIFICATION

- Probable: A clinically compatible case as reported by the patient or healthcare provider, absence of a more likely explanation and virus-specific IgM antibodies in serum but with no other testing
- Confirmed: A clinically compatible case as reported by the patient or healthcare provider, absence of a more likely explanation, and confirmatory laboratory results

COMMENT**Rule Out Dengue Testing**

The differential diagnosis of chikungunya virus infection varies based on place of residence, travel history, and exposures. Dengue and chikungunya viruses are transmitted by the same mosquitoes and have similar clinical features. The two viruses can circulate in the same area and can cause occasional co-infections in the same patient. Chikungunya virus infection is more likely to cause high fever, severe arthralgia, arthritis, rash, and lymphopenia, while dengue virus infection is more likely to cause neutropenia, thrombocytopenia, hemorrhage, shock, and death. It is important to rule out dengue virus infection because proper clinical management of dengue can improve outcome.

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.
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"> • Adult film actor/actress • 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 - server • 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 - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown