

**Case Investigation and Specimen Collection Form for Dengue
Fever/Dengue Hemorrhagic fever (Version-1)**

Case type please tick: Dengue Fever Dengue Hemorrhagic fever

Patient Information

Name of Health Centre:	Date DD/MM/YY
Patient Name:	Age/Sex:
Contact Number:	Occupation:
Residential Address:	

Clinical Information

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Retro orbital pain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joints pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Myalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Backache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Haematemesis or melenas	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Petechiae, ecchymoses, or purpura	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Altered mental status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea/vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Restless	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Others (Specify):		

Co morbid conditions (Check all that apply)

None Diabetes Cardiac Disease Hypertension Pregnancy

BP _____ Pulse _____ Temp _____

Hospitalization: Yes No Date of Admission: _____

Outcome: Recovered Referred Death

Epidemiological Information

Date of notification: _____ Date of onset of symptoms: _____

Residing in dengue endemic places Yes No

Have you travel to dengue endemic places: Yes No If yes, place visited _____

Travel dates: From _____ To _____

Laboratory information

Laboratory Specimen Collected: Yes No Sample ID _____

Lab result CBC Yes No if yes

WBC _____ HB _____ HCT _____ PLT _____

Lab result RDT : NS1 positive IgM positive IgG positive

Lab result ELISA: (RCDC) positive Negative:

Triplex RT-PCR result (RCDC) DENV positive CHICK positive ZIKAV positive

_____:

Sample Collected by: Name: _____

Contact #: _____