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CHIKUNGUNYA INVESTIGATION FORM

INITIAL DIAGNOSIS	
Initial Diagnosis/Notification: Chikungunya	
Date of Notification: DD/MM/YYYY	Date Investigation Started: DD/MM/YYYY
PATIENT'S DEMOGRAPHICS	
Patient's ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN	Patient's ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Sex Assigned at Birth: ◯ Male ◯ Female	Medical Record Number:
Date of Birth: DD/MM/YYYY	Age:
Country of Residence:	Parish (Jamaica):
House Number, Street Name:	
Landmark or directions to address:	Community:
Phone Number:	Email Address:

CLINICAL PROFILE		
◯ History of Fever ◯ Recorded Fever		
Recorded temperature:	Duration (days):	Date of Onset: DD/MM/YYYY

Sign or Symptom	Presence	Date of Onset
Arthralgia	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Severe arthralgia	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Myalgia	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Arthritis	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
- Hands	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
- Wrist	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
- Feet	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
- Ankle	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Back pain	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Headache	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Nausea	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Mucosal bleeding	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Vomiting	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Asthenia (generalized weakness)	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Skin manifestations	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Periarticular oedema	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY

Description of Skin Manifestation (if Applicable):

Medical History

Pre-existing Conditions

◯ Asthma	◯ Diabetes mellitus	◯ HIV/AIDS	◯ Malignancy
◯ Autoimmune Condition	◯ Heart Disease	◯ Hypertension	◯ Sickle Cell Disease
◯ Chronic Obstructive Pulmonary Disease (COPD)	◯ Kidney disease	◯ Liver dysfunction	◯ Other Specify Other:

Pregnancy

Is Patient Pregnant: ◯ Yes ◯ No ◯ Unsure ◯ Not Applicable

Gestational Age: | Trimester: ◯ First ◯ Second ◯ Third

EXPOSURE PROFILE

Has the person had contact with a confirmed Chikungunya case in the last 3 weeks? ◯ Yes ◯ No ◯ Unknown

Date of Exposure: *DD/MM/YYYY* | Comment:

TRAVEL PROFILE

Are there other cases present in the patient's community of residence? ◯ Yes ◯ No

Travelled in the Last 3 weeks: ◯ Yes ◯ No ◯ Unknown

If travelled: ◯ Domestic Travel ◯ International Travel ◯ Domestic and International Travel

If International Travel, fill out the table below:

Country Visited	City Visited	Accommodation	Date Arrived in Country	Date Departed Country
			DD/MM/YYYY	*DD/MM/YYYY*
			DD/MM/YYYY	*DD/MM/YYYY*
			DD/MM/YYYY	*DD/MM/YYYY*
			DD/MM/YYYY	*DD/MM/YYYY*

Date returned to Jamaica: *DD/MM/YYYY*

If Local Travel, fill out the table below:

Address	Parish	Date Arrived	Date Departed
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*

Date returned to home address: *DD/MM/YYYY*

SAMPLE AND LAB INFORMATION

Blood Tests - Collection Details				Specimen - Laboratory Details			
Specimen Number	**Test Name**	**Date Specimen Collected**	**Date Specimen Sent to Lab**	**Date/time received by laboratory**	**Adequacy for testing**	**Quantitative Test result**	**Test result**
	◯ Virus Isolation ◯ IgM ELISA ◯ IgG antibody by HAI test ◯ RT-PCR ◯ Other: __________	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Negative ◯ Indeterminate ◯ Unknown
	◯ Virus Isolation ◯ IgM ELISA ◯ IgG antibody by HAI test ◯ RT-PCR ◯ Other: __________	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Negative ◯ Indeterminate ◯ Unknown

Is the sample being sent to an external lab? ◯ Yes ◯ No

◯ National Public Health Laboratory ◯ CARPHA ◯ Other

Specify Other Laboratory:

HOSPITAL SUMMARY		
Admitted to Hospital? ◯ Yes ◯ No	Date of Admission: DD/MM/YYYY	Date of Discharge: DD/MM/YYYY
Hospital:	Medical Record Number:	
Vital Status (Outcome): ◯ Alive ◯ Dead	Date of Death: DD/MM/YYYY	Time of Death: __:__ AM/PM
Place of Death: ◯ Home ◯ Dead on Arrival ◯ Ward ◯ ICU ◯ Other, Specify: _______________		
CLINICAL MANAGEMENT		
Summary of Clinical Management:		
Classification		
Initial Diagnosis: Chikungunya	**Final Diagnosis:**	
Case classification:		
◯ Laboratory Confirmed	◯ Probable	◯ Suspected
◯ Pending	◯ Inconclusive	◯ Discarded
Reason for classification:		
Aetiology Category: ◯ Imported case ◯ Import-related cases ◯ Endemic/Local Transmission ◯ Unknown		
Source country (If Imported or Import-Related):		
DEATH CLASSIFICATION		
Did Chikungunya contribute to patient's death? ◯ Yes ◯ No ◯ Unknown		
Immediate Cause:		
Intermediate Cause:		
Underlying Cause:		
Investigator's Comments:		
ENVIRONMENTAL SURVEY		
Community planning: ◯ Planned ◯ Unplanned	Water supply: ◯ Piped ◯Stored	
Waste collection frequency: ◯ Frequent ◯ Infrequent	Mosquito population: ◯ Aegypti ◯ Albopictus	

Aedes Indices

Home Indices	**Numerator**	**Denominator**
Premises index (PI)		
Container index (CI)		
Breteau index (BI)		
School/Workplace Indices		
Premises index (PI)		
Container index (CI)		
Breteau index (BI)		

Investigator's Details	**Public Health Inspector Details**
Date Investigation Completed: *DD/MM/YYYY*	Date Environmental Survey Completed: *DD/MM/YYYY*
First Name:	First Name:
Last Name	Last Name
Professional Group:	Professional Group:
Phone number:	Phone number:
Email Address:	Email Address:
Name of Institution:	Name of Institution:
Community:	Community:
Parish:	Parish:
Investigator's Office Number/Street Name:	
Investigator's Health Region:	

Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): *DD/MM/YYYY*