



Case Investigation Form

Chikungunya Virus Disease (ICD 10 Code: A92.0)

<b>Name of DRU:</b>		Type: ( ) RHU ( ) CHO ( ) Gov't Hospital ( ) Private Hospital ( ) Clinic					
<b>Address:</b>		( ) Gov't Laboratory ( ) Private Laboratory ( ) Airport/Seaport					
<b>I. PATIENT INFORMATION</b>	Patient Number:	Patient's First Name		Middle Name:		Last Name	
Complete Address:		Sex: ( ) Male ( ) Female	Date of Birth	MM	DD	YY	Age: ( ) Days ( ) Months ( ) Years
Patient Admitted? ( ) Yes ( ) No ( ) Unknown		Date Admitted/Seen/Consult	MM	DD	YY	Date Onset of Illness	MM DD YY
Date of Report	MM	DD	YY	Date of Investigation	MM	DD	YY

**II. CLINICAL INFORMATION**

Number of days with symptoms: \_\_\_\_\_ Morbidity week: \_\_\_\_\_

<b>Symptoms</b>	YES	NO
Fever ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where:		
Hands ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
Feet ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
Ankles ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
Other ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
Arthralgia ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
Periarticular edema ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>
Skin manifestations ( ) Yes ( ) No	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe: \_\_\_\_\_ Outcome: ( ) Alive ( ) Died Date died: \_\_\_/\_\_\_/\_\_\_

Other S/Sx: \_\_\_\_\_

**Clinical Diagnosis** \_\_\_\_\_

**III. LABORATORY INFORMATION**

Blood sample testing for CHIKV infection:

Date of collection: \_\_\_/\_\_\_/\_\_\_ Date sent to RITM: \_\_\_/\_\_\_/\_\_\_

Serology-IgM Yes ( ) No ( )  
Result: Positive ( ) Negative ( ) Date of Result: \_\_\_/\_\_\_/\_\_\_

Serology-IgG Yes ( ) No ( )  
Result: Positive ( ) Negative ( ) Date of Result: \_\_\_/\_\_\_/\_\_\_

RT-PCR Yes ( ) No ( )  
Result: Positive ( ) Negative ( ) Date of Result: \_\_\_/\_\_\_/\_\_\_

Viral Isolation Yes ( ) No ( )  
Result: Positive ( ) Negative ( ) Date of Result: \_\_\_/\_\_\_/\_\_\_

**IV. EPIDEMIOLOGICAL INFORMATION**

History of travel within the previous 30 days prior to symptom onset: Yes ( ) No ( )

If yes, where: \_\_\_\_\_

Place of residence: \_\_\_\_\_

Have you received blood or blood products within the previous 30 days prior to symptom onset? Yes ( ) No ( )

**FINAL CLASSIFICATION:**

Discarded: ( ) Confirmed: ( ) Date of notification: \_\_\_/\_\_\_/\_\_\_  
Suspected: ( )

Name of reporting personnel: \_\_\_\_\_ Contact Number/s: \_\_\_\_\_

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**Chikungunya Virus Disease**

**CASE DEFINITION/CLASSIFICATION:**

**Suspected case:** a patient with acute onset of fever, rash (over limbs or trunk) and severe arthralgia or arthritis not explained by other medical conditions.

**Confirmed case:** a suspect case with any of the following CHIK specific tests:

- Detection of viral RNA by RT-PCR.
- Detection of IgM in a single serum sample (collected during acute or convalescent phase).
- Four-fold increase in CHIKV-specific antibody titers (samples collected at least two to three weeks apart).
- Viral isolation.

*During an epidemic, all patients need not be subjected to confirmatory tests as above.  
An epidemiologic link can be sufficient.*