

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**YELLOW FEVER
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 48**

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U

If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CHECK ALL THAT APPLY:

Fever Y N U

Yes, subjective No

Yes, measured Unknown

Highest measured temperature _____

Fever onset date (mm/dd/yyyy): ___/___/___

Was the fever recurring, remittent, or intermittent? Y N U

Hepatitis (inflamed liver) Y N U

Etiology: Viral Non-viral Unknown

Albuminuria Y N U

CLINICAL FINDINGS

Pulse-temperature dissociation Y N U

Chills or rigors Y N U

Prostration Y N U

Shock Y N U

Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia) Y N U

Onset date (mm/dd/yyyy): ___/___/___

Acute liver failure Y N U

Acute renal failure Y N U

Leukopenia Y N U

Hemorrhagic symptoms/signs Y N U

Specify (check all that apply):

Petechiae

Ecchymosis

Purpura

Conjunctival hemorrhage

Nasal bleeding (epistaxis)

Gingival bleeding

Vomiting blood (hematemesis)

Frank blood in stool

Blood in urine (hematuria, i.e., urinalysis >5 RBC/hpf or positive for blood)

Vaginal bleeding

Melena

Other _____

Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U

Specify: _____

PREGNANCY

Is the patient currently pregnant? Y N U

Estimated delivery date: ___/___/___

Is patient a post-partum mother (<=6 weeks)? Y N U

Has the patient been pregnant in the past 12 months? Y N U

Did patient experience onset of symptoms within 6 weeks of delivery? Y N U

MATERNAL INFORMATION

Was the child breastfed? Y N U

Did the biological mother ever have evidence of serological IgG immunity? Y N U

Test date: ___/___/___

Result: Positive Negative Equivocal Unk.

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) _____ - _____

Admit date (mm/dd/yyyy): ___/___/___

Discharge date (mm/dd/yyyy): ___/___/___

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

VECTOR EXPOSURE

During the 14 days prior to onset, did the patient have an opportunity for exposure to mosquitoes? Y N U

Exposed on (mm/dd/yyyy): ____/____/____

Until (mm/dd/yyyy): ____/____/____

Frequency:

Once

Multiple times within this time period

Daily

County of exposure _____

State of exposure _____

Country of exposure _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U

Date of interview (mm/dd/yyyy): ____/____/____

Medical records reviewed (including telephone review with provider/office staff)? Y N U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

TRAVEL & IMMIGRATION

The patient is:

Resident of NC

Resident of another state or US territory

Foreign Visitor

Refugee

Recent Immigrant

Foreign Adoptee

None of the above

Did patient have a travel history during the 14 days prior to onset? Y N U

List travel dates and destinations:

From ____/____/____ to ____/____/____

Additional travel/residency information:

VACCINE

Has patient ever received vaccine related to this disease? Y N U

Vaccine type _____

Unknown vaccine or immune globulin

Date of administration (mm/dd/yyyy): ____/____/____

Source of this vaccine information _____

How many days prior to illness onset was vaccine received?

Fewer than 14 days

14 days or more

Vaccine date unknown

Yes No

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC

City _____

County _____

Outside NC, but within US

City _____

State _____

County _____

Outside US

City _____

Country _____

Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

Yellow Fever

1997 CDC Case Definition

Clinical description

A mosquito-borne viral illness characterized by acute onset and constitutional symptoms followed by a brief remission and a recurrence of fever, hepatitis, albuminuria, and symptoms and, in some instances, renal failure, shock, and generalized hemorrhages

Laboratory criteria for diagnosis

- Fourfold or greater rise in yellow fever antibody titer in a patient who has no history of recent yellow fever vaccination and cross-reactions to other flaviviruses have been excluded or
- Demonstration of yellow fever virus, antigen, or genome in tissue, blood, or other body fluid

Case classification

Probable: a clinically compatible case with supportive serology (stable elevated antibody titer to yellow fever virus [e.g., greater than or equal to 32 by complement fixation, greater than or equal to 256 by immunofluorescence assay, greater than or equal to 320 by hemagglutination inhibition, greater than or equal to 160 by neutralization, or a positive serologic result by immunoglobulin M-capture enzyme immunoassay]. Cross-reactive serologic reactions to other flaviviruses must be excluded, and the patient must not have a history of yellow fever vaccination.)

Confirmed: a clinically compatible case that is laboratory confirmed