

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

YELLOW FEVER CASE REPORT

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence		Apartment/Unit Number		Ethnicity (check one)	
City/Town		State	Zip Code	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Census Tract	County of Residence	Country of Residence		Race* (check all that apply, race descriptions on page 6)	
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		<input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply)	
Home Telephone	Cellular Phone/Pager	Work/School Telephone		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Thai <input type="checkbox"/> Hmong <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____	
E-mail Address		Other Electronic Contact Information		<input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____	
Work/School Location		Work/School Contact		<input type="checkbox"/> White <input type="checkbox"/> Other: _____	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, Est. Delivery Date (mm/dd/yyyy)		<input type="checkbox"/> Unk	
Medical Record Number		Patient's Parent/Guardian Name		*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.	
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	

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 and Symptoms				Yes	No	Unk	Signs and Symptoms			Yes	No	Unk
Fever, If Yes, <i>highest temperature (specify °F/°C)</i>							Abdominal pain					
Chills							Hematemesis					
Severe headache							Epistaxis					
Muscle aches							Gum bleeding					
Nausea							Purpura hemorrhages					
Fatigue							Deepening jaundice					
Weakness							Proteinuria					
Back pain												
Other signs / symptoms (specify)												
VACCINATION / MEDICAL HISTORY												
Vaccinated for yellow fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			If Yes, date of first vaccine (mm/dd/yyyy)				Date of most recent booster (mm/dd/yyyy)					
CLINICAL COMPLICATIONS												
Clinical complications for this attack? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			If Yes, specify									
Other (specify)												
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?				
If there were any ER or hospital stays related to this illness, specify details below.												
HOSPITALIZATION - DETAILS												
Hospital Name 1		Street Address				Admit 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				Admit 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)			

First three letters of patient's last name:

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ADDITIONAL COMMENTS

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

<i>Specimen Type 1</i> <input type="checkbox"/> Blood <input type="checkbox"/> Other (specify): _____	<i>Type of test</i> <input type="checkbox"/> Smear <input type="checkbox"/> Serology (Specify): _____ <input type="checkbox"/> Other (specify): _____	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <i>Results</i>
<i>Laboratory Name</i>		<i>Telephone Number</i>

<i>Specimen Type 2</i> <input type="checkbox"/> Blood <input type="checkbox"/> Other (specify): _____	<i>Type of test</i> <input type="checkbox"/> Smear <input type="checkbox"/> Serology (Specify): _____ <input type="checkbox"/> Other (specify): _____	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <i>Results</i>
<i>Laboratory Name</i>		<i>Telephone Number</i>

OTHER LABORATORY TESTS

<i>Test for other flaviviruses?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify flavivirus(es)</i>	<i>Outcome of Tests</i>
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EPIDEMIOLOGIC INFORMATION

TRAVEL HISTORY (INCUBATION PERIOD IS 3 MONTHS PRIOR TO ILLNESS ONSET)

<i>Did patient travel or live outside of the U.S. during the incubation period?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify the following and all locations and dates below.</i>
<i>Principal reason for travel from / to U.S. for most recent trip</i> <input type="checkbox"/> Tourism <input type="checkbox"/> Military <input type="checkbox"/> Peace Corps <input type="checkbox"/> Business <input type="checkbox"/> Airline / ship crew <input type="checkbox"/> Student / teacher <input type="checkbox"/> Visiting friends / relatives <input type="checkbox"/> Missionary or dependent <input type="checkbox"/> Refugee / immigrant <input type="checkbox"/> Other (specify): _____	

TRAVEL HISTORY - DETAILS

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

First three letters of patient's last name:

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CONTACTS / OTHER ILL PERSONS

Any contacts with similar illness?
Yes No Unk If Yes, specify details below.

ILL CONTACTS - DETAILS

<i>Name 1</i>	<i>Age</i>	<i>Gender</i>	<i>Telephone Number</i>	<i>Type of Contact / Relationship</i>	<i>Date of Contact (mm/dd/yyyy)</i>
	<i>Street Address</i>			<i>Exposure Event</i>	<i>Illness Onset Date (mm/dd/yyyy)</i>
	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Date First Reported to Public Health (mm/dd/yyyy)</i>	
<i>Name 2</i>	<i>Age</i>	<i>Gender</i>	<i>Telephone Number</i>	<i>Type of Contact / Relationship</i>	<i>Date of Contact (mm/dd/yyyy)</i>
	<i>Street Address</i>			<i>Exposure Event</i>	<i>Illness Onset Date (mm/dd/yyyy)</i>
	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Date First Reported to Public Health (mm/dd/yyyy)</i>	

NOTES / REMARKS

REPORTING AGENCY

<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date of First Report (mm/dd/yyyy)</i>
<i>First Reported By</i> <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____		<i>Officer Releasing Antitoxin - Last Name, First Name</i>	

EPIDEMIOLOGICAL LINKAGE

<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>
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DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 5)
Confirmed Probable Suspect

OUTBREAK

<i>Part of known outbreak?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, extent of outbreak:</i> <input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
<i>Vehicle of Outbreak</i>	<i>Pattern 1 ID number</i>	<i>Pattern 2 ID number</i>	

First three letters of patient's last name:

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STATE USE ONLY

State Case Classification
 Confirmed Probable Suspect Not a case Need additional information

CASE DEFINITION

YELLOW FEVER (2010)

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.

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