Appendix D. Example of a Case Report Form

Basic Data
Last name ______________________________ First name: __________________________

Sex: ( ) male ( ) female
Date of birth: _____/____/____/    age: |__|__| years |__|__|months |__|__|days
Occupation: ________________________________________________________________
Address: __________________________________________________________________
Zipcode: |__|__|__|__|__|__|__| telephone number: |__|__|__|__|__|__|__|

Clinical Information
Clinical history number: ______________________
Date of symptom onset: ____/_____/____/ Epidemiological week: |__|__|
Number of days with symptoms:  ____/_____/  Date of first medical consult: ____/_____/____/
Date of hospitalization: ____/_____/____/
Death: Yes ( )  No ( ) Date: ____/_____/____/

Symptoms
Yes No
Fever □ □ Myalgia □ □
Arthritis □ □ Back pain □ □
    If yes, where:
    Hands □ □ Head ache □ □
    Feet □ □ Nausea □ □
    Ankles □ □ Mucosal bleeding □ □
    Other □ □ Vomiting □ □
Arthralgia □ □ Asthenia □ □
Periarticular edema □ □
Skin manifestations □ □ Meningoencephalitis □ □
    If yes, describe: ______________________________
Other ______________________________________________________________________

Clinical diagnosis ____________________________________________________________

Laboratory Information

Blood sample testing for CHIKV infection:
Date of collection: _____/_____/____/

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 _____/_____/____/
Epidemiological information

- History of travel within the previous 30 days prior to symptom onset: Yes ☐ No ☐
  - If yes, where: Country ________________ City ________________
- Place of residence: Community ____________________________ Locality ____________________________
- Have you received blood or blood products within the previous 30 days prior to symptom onset? Yes ☐ No ☐

Final classification:

- Discarded: |__|
- Confirmed: |__|
- Suspected: |__|
- Date of notification: _____/_____/_____

Name of reporting personnel: ________________________________