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VIRAL HAEMORRHAGHIC FEVER (VHF): CASE PROFORMA

Details of Hospital/DSU:_____ Unique ID: _____

Sample collection Date: _____ Type of Sample: Serum | EDTA blood | Urine | CSF | Others |

Section A: Patient Information

Name: (First, Middle, Last):_____ Age:_____Years_____months

Sex: Male/Female ☐ Occupation: Farmer/ Animal handler/ Health care worker/ Other ☐

Village/City/ Town:_____District:_____ Contact number: _____

Onset date:_____ Admission date: _____

Previous hospital visit 1 Previous hospital visit 2 Previous hospital visit 3

_____date: _____ _____date: _____ _____date: _____

Section B: Any of the following signs / symptoms within last 10 days

Fever	Yes	☐	No	☐	Not Known	☐	Jaundice	Yes	☐	No	☐	Not Known	☐
Fatigue	Yes	☐	No	☐	Not Known	☐	Pain behind eyes	Yes	☐	No	☐	Not Known	☐
Muscle pain	Yes	☐	No	☐	Not Known	☐	Cough	Yes	☐	No	☐	Not Known	☐
Joint pain	Yes	☐	No	☐	Not Known	☐	Sore throat	Yes	☐	No	☐	Not Known	☐
Headache	Yes	☐	No	☐	Not Known	☐	Breathing Difficulty	Yes	☐	No	☐	Not Known	☐
Nausea	Yes	☐	No	☐	Not Known	☐	Chest pain	Yes	☐	No	☐	Not Known	☐
Vomiting	Yes	☐	No	☐	Not Known	☐	Conjunctivitis	Yes	☐	No	☐	Not Known	☐
Diarrhea	Yes	☐	No	☐	Not Known	☐	Seizures	Yes	☐	No	☐	Not Known	☐
Abdominal pain	Yes	☐	No	☐	Not Known	☐	Altered sensorium	Yes	☐	No	☐	Not Known	☐
Anorexia	Yes	☐	No	☐	Not Known	☐	Altered behavior	Yes	☐	No	☐	Not Known	☐
Skin Rash	Yes	☐	No	☐	Not Known	☐	Type of Rash	Petechiae	☐	Purpura	☐	Ecchymoses	☐
Microcephaly	Yes	☐	No	☐	Not Known	☐	GBS	Yes	☐	No	☐	Not Known	☐

Any bleeding:☐ Site: _____ Other Symptoms/sign: _____

Section C: Epidemiological Risk Factors and Exposures (<1 month)

Travel outside hometown/village: Yes ☐ No ☐ if Yes details: _____

Mosquito / Tick/ Other insect exposure: Yes ☐ No ☐ Not known ☐

Contact with patient having similar illness: Yes ☐ No ☐ Not known ☐

Contact with livestock: Yes ☐ No ☐ Contact with VHF case: Yes ☐ No☐ if yes details: _____

Handling of clinical specimen: Yes ☐ No ☐ Any other exposure: _____

Vaccination in last month :- Yes / No if Yes Detail _____

Section D: Laboratory Findings

Hb: _____ TLC: _____ Neutrophils (%): _____ Lymphocytes (%): _____ Platelet count: _____

ESR: _____ PT: _____ aPTT: _____ Serum Bilirubin: _____ AST/SGOT: _____

ALT/SGPT: _____ ALK Phos: _____ Serum protein: _____ Albumin: _____ Globulin: _____

Serum Creatinine: _____ Blood Urea: _____ LDH: _____ CPK: _____ FDP: _____

Proteinurea :_____ Other Lab result: _____

Leptospirosis: Pos ☐ Neg ☐ ND ☐ Typhoid: Pos ☐ Neg ☐ ND ☐

Malaria: Pos ☐ Neg ☐ ND ☐ Scrub typhus: Pos ☐ Neg ☐ ND ☐

Section E: **Hospitalization Details**

Hospitalized ? Yes / No, If Yes Admitted __/__/__ Discharged __/__/__ Died from illness No/Yes, date__/__/__

Diagnosis _____ Differential diagnosis_____

Treatment _____

Remarks _____

Section F: Referral Details

Name of Doctor: _____ Department Name: _____

Email :_____

Phone no : _____

Specimen referred to NIV Pune: Yes ☐ No ☐

Section G: Antenatal Clinic Details

Name of Doctor: _____

Pregnant with Dengue-like illness: Yes ☐ No ☐ Gestational week: _____

Center results details

Laboratory Result: Positive / Negative

Dengue: Positive ☐ Negative ☐ NS1 ☐ IgM ☐ RT-PCR ☐ qRT-PCR ☐

CHIK: Positive ☐ Negative ☐ IgM ☐ qRT-PCR ☐

Zika: Positive ☐ Negative ☐ qRT-PCR ☐ RT-PCR ☐

For NIV Use Only

NIV Lab ID: _____ Sample type : _____ Sample Volume :_____

NIV Remarks: _____