Appendix D. Example of a Case Report Form

Date of symptom onset: \_\_\_\_/\_\_\_\_/\_\_\_\_/ Epidemiological week |\_\_|\_\_|

Number of days with symptoms: \_\_\_\_/\_\_\_\_\_/ Date of first medical consult: \_\_\_\_/\_\_\_\_/\_\_\_\_/

Date of hospitalization: \_\_\_\_/\_\_\_\_/\_\_\_\_/

Death: Yes ( ) No ( ) Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_/

**Clinical Information**

Zipcode: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| telephone number: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

age: |\_\_|\_\_| years |\_\_|\_\_|months |\_\_|\_\_|days

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_/

Sex: ( ) male ( ) female

**Basic Data**

Viral isolation

Result:

RT-PCR

Result:

Serology - IgG

Result:

Date of result \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/

Date of result \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/

Date of result \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/

Date of result \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/

Negative

No

Yes

Positive

Positive

Yes

No

Negative

Yes

Positive

No

Negative

Negative

No

Yes

Positive

Result:

Serology - IgM

Date of collection: \_\_\_\_/\_\_\_\_/\_\_\_\_/

**Blood sample testing for CHIKV infection:**

If yes, where:

No

Yes

Yes

**Laboratory information**

**Clinical diagnosis** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin manifestations

Periarticular edema

Arthralgia

No

Meningoencephalitis

Asthenia

Vomiting

Mucosal bleeding

Nausea

Headache

Back pain

Myalgia

Fever

Arthritis

***Symptoms***

Other

Ankles

Feet

Hands

Clinical history number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix D. Example of a Case Report Form (Cont.)

**Epidemiological information**

No

**Name of reporting personnel:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of notification: \_\_\_\_/\_\_\_\_/\_\_\_\_/

Suspected: |\_\_|

Confirmed: |\_\_|

Discarded: |\_\_|

**Final classification:**

Yes

Blood or blood products received within the previous 30 days prior to symptoms onset1

Community \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Locality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of residence:

If yes, where: Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

Yes

History of travel within the previous 30 days prior to symptom onset: