

Appendix 2: Example MVEV Case Investigation Form

Notification ID: _____

Date and time notified: _____

Notified by: _____ Organisation/Hospital: _____ Phone: _____

Final classification: Confirmed Probable Rejected

Date questionnaire completed: _____

Person(s) interviewed:

- Case
- Parent/guardian, (specify) _____
- Spouse/other family member (specify) _____
- General Practitioner (name) _____
- Treating Doctor (name) _____
- Other, specify _____

Please indicate who completed this form:

- Public health officer
- EHO (Name & Local Govt): _____
- Other: _____

Section 1: Case Details

First name: _____ Surname: _____

Gender: M F Date of Birth (day/month/year) : ____/____/____

Is the case of Aboriginal or Torres Strait Islander origin:

- Non Indigenous Aboriginal Torres Strait Islander (TSI)
- Aboriginal and TSI Unknown

Residential address (not PO Box): _____

Town/Suburb: _____

State: _____ Postcode: _____ Country _____

Phone: (Home) _____ Phone (mobile): _____ Phone (work): _____

Country of birth: _____ Year of arrival: _____

Occupation: _____

Occupation requires work mostly: Indoors Outdoors

Status

- Alive
- Died due to notifiable disease_date ___/___/_____
- Died due to other/unknown cause date ___/___/_____
- Unknown

Doctor details: General practitioner

Doctor name: _____ Clinic name: _____

Address: _____

Phone (work) _____ Fax (work) _____ Email: _____

Section 2: Laboratory Criteria

Name of Laboratory: _____

Date result available: _____

Specimen collection date: _____

Type(s) of specimen

- Blood
- Cerebrospinal fluid
- Other: _____

Results

	Yes	No	Equiv.	Pending	Specimen type
MVE virus isolation					
Nucleic acid test: PCR +ve					
MVEV IgG +ve (initial bleed)					

	Yes	No	Equiv.	Pending	Bleed date 1	Bleed date 2	Titre (serology)
MVEV IgG +ve (initial bleed)							
MVEV IgG +ve (second bleed)							
MVEV IgM +ve (encephalitic illness Y/N)							
Virus neutralisation							

serology							
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Confirmation at second laboratory: Yes No;
 If yes, name of second laboratory _____

Confirmation of laboratory result by a second arbovirus reference laboratory is required if the case occurs in areas of Australia not known to have established enzootic/ endemic activity or regular epizootic/epidemic activity, see case definitions available from the [Health website](http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-nndss-casedefs-cd_mve.htm) (http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-nndss-casedefs-cd_mve.htm).

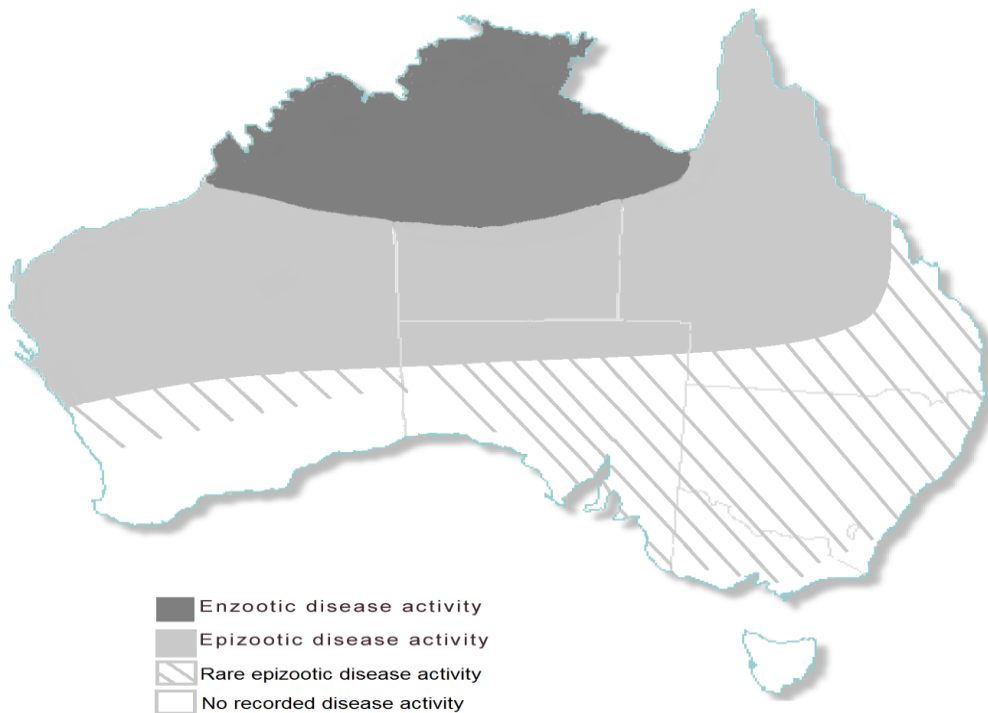


Figure 1. MVEV enzootic and epizootic regions in Australia

Has the case tested positive for MVEV before? Yes No
 If yes, give details _____

Has the case tested positive for any other arbovirus before? Yes No
 If yes, give details _____

Section 3: Illness details

Date of onset (D/M/Y): ___/___/___ Date of first consultation: ___/___/___

Total duration of illness: days hours

Symptom profile

No symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Neck Stiffness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Photophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Muscle aches and pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Impaired consciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Confusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Difficulty walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Young children: Drowsiness/floppy/irritability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other: Specify _____			

History of illness from case or proxy:

History of illness from treating doctor:

Section 4: Hospital presentationDid the case present to hospital? No Yes → Date presented to hospital ___/___/___Admitted to hospital: No Yes

If admitted, Hospital Name(s): _____ UR no: _____
 Date admitted: (D/M/Y) ____/____/_____
 Date discharged: (D/M/Y) ____/____/_____

Treating doctor / Unit: _____
 Discharge summary requested: No Yes -> Date ____/____/_____

Section 5: Exposure period

Calculated exposure period (Onset – 28 days) to (Onset – 5 days): ____/____/____ to ____/____/____

Did the case travel in the 4 weeks before onset of symptoms? No Yes → Within the State Interstate Overseas

During the exposure period, please indicate **all** suburbs/s or town/s (**Australian and overseas**) in which the person resided, worked or visited
 Leave blank if information not available or unknown

	Address/Suburb/Town/ Country	Dates (arrival and departure)	Activity at this place	Building features	Noticed mosquitoes	Recall being bitten by mosquitoes here?
1			Reside / Work / Visit	Screens / aircon	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2			Reside / Work / Visit	Screens / aircon	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3			Reside / Work / Visit	Screens / aircon	Yes No	Yes No
4			Reside / Work / Visit	Screens / aircon	Yes No	Yes No
5			Reside / Work / Visit	Screens / aircon	Yes No	Yes No
6			Reside / Work / Visit	Screens / aircon	Yes No	Yes No
7			Reside / Work / Visit	Screens / aircon	Yes No	Yes No
8			Reside / Work / Visit	Screens / aircon	Yes No	Yes No

Notes to interviewer: Where possible ask the person to identify the location down to a street or lot number or a particular part of a recreational area (e.g. wetland, nature reserve, golf course, etc).

Section 6: Further details of location/activities/behaviour whilst in the place they were most likely to be have acquired their infection

What activities were they doing (camping/fishing/gardening)?

What type of accommodation? (tents / hotels / hostel)

Where did they notice mosquitoes - indoors/outdoors, near water bodies, in the bush, etc?

Did the case report use: (a) of personal mosquito repellent? Yes No; (b) protective clothing Yes No (c) mosquito nets? Yes No

Does the case know of other persons who have been to the same place who have become ill? Yes No (If Yes, seek further details)

Section 7: Co-exposed

Co-exposed can be defined as persons who have had the same exposure/s as the case including household members and persons who travelled with the case.

	Age	Recent MVE-like illness
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No

Section 8: Public Health Action

Mosquito precautions discussed: Yes No

Fact sheet sent:

Yes No

Other:

Section 9: Interviewer

Name: _____

Signature: _____

Date: __/__/__
