

PROVINCIAL LABORATORY FOR PUBLIC HEALTH (MICROBIOLOGY)

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ARBOVIRUS - PATIENT HISTORY FORM

Patient Name: _____ DOB: _____ Sex: _____

PHN: _____

Submitting Physician: _____

Physician Phone No.: _____ Fax No. _____ Pager: _____

Date of onset of symptoms: _____ (very important!)

Acute clinical features (Please circle all that apply):

- | | | | |
|---------------------------|--------------------------|-----------------------------------|-----------------------------|
| Fever (120) | Maculopapular rash (254) | Generalized lymphadenopathy (184) | Altered mental status (785) |
| Cranial nerve palsy (789) | Muscle weakness (786) | Flaccid paralysis (787) | Tremor (791) |
| Seizures (268) | Sensory deficits (794) | SIADH (793) | |

Other relevant symptomatology: _____

CSF WBC count _____ predominantly Neutrophils Lymphs

- Blood transfusion within 8 weeks of onset (783) Date: _____
- Blood donation within 8 weeks of onset (796) Date: _____
- Organ/tissue donation within 8 weeks of onset (446) Date: _____
- Pregnant (238) Due Date: _____

Immunocompromised:

- Transplant (465) Leukemia (386) Other
- Steroids (797) Lymphoma (388)

History of travel within 3 weeks before onset (please specify): _____

History of vaccination for: Yellow Fever Approx. date _____

Japanese encephalitis Approx. date _____

Past residence in tropical regions : No Yes _____
(To assess Dengue, JE cross-reactivity)