

CASE REPORT FORM

1. Inclusion / Exclusion Criteria (NOTE: Please use a ✓)

1.1 Inclusion Criteria

Informed consent obtained

1.2 Exclusion Criteria

Any condition that, in the opinion of the investigator, would complicate or compromise the study or well being of the patient.

2. Demographic Information at Enrolment

Date of enrolment []/[]/[] dd/mm/yy

Age in year []

Sex Male Female

If female, does the patient have a known pregnancy? yes no

Weight on enrolment [] kg Height [] cm

Body Mass Index (BMI) [] / [] kg/m²

2.1 Vital Signs

Temperature [] °C

Blood pressure (systolic) [] /mmHg

(diastolic) [] /mmHg

Pulse [] per minute

Respiratory rate* [] per minute *after rested at least 5 minutes

3. CLINICAL DEFINITION OF DENGUE (DK="don't know")

Medical Condition	Y/N/DK	Severity (1-3=mild, 4-7=moderate, 8-10 severe)	Days present
Malaise		Severity ____	
Flushing		Severity ____	
Vomiting <i>If yes, number of episodes</i> ____			
Nausea		Severity ____	
Diarrhoea <i>If yes, number of episodes</i> ____			
Muscle pain		Severity ____	

Joint pain		Severity ____	
Retroorbital pain		Severity ____	
Rash <i>If yes, please indicate below:</i> <input type="checkbox"/> maculopapular <input type="checkbox"/> erythematous		Severity ____	
Headache		Severity ____	
Conjunctivitis		Severity ____	
Bleeding <i>If yes, please indicate below:</i> <input type="checkbox"/> gums <input type="checkbox"/> nose <input type="checkbox"/> Ecchymosis <input type="checkbox"/> epistaxis <input type="checkbox"/> GI <input type="checkbox"/> petechiae <input type="checkbox"/> Vaginal <input type="checkbox"/> other, _____ <input type="checkbox"/> Urinary tract			
Edema <i>If yes, please indicate below:</i> (1=periph.; 2=facial; 3=peri+fac.) <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unclear/not assessed <i>If 'yes', code <input type="checkbox"/></i>			
Fever <i>If yes, please indicate below:</i> Temperature <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> °C Date of fever onset: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> dd/mm/yy Time of fever onset: <input type="checkbox"/> <input type="checkbox"/> : <input type="checkbox"/> <input type="checkbox"/> hh:mm Number of days of fever at the time of enrollment			
Respiratory distress Comments (if any) _____			
Chest pain / discomfort		Severity ____	
Abdominal pain / discomfort		Severity ____	
Ascites Comments (if any) _____			
Liver enlargement >2cm			
Pleural effusion Comments (if any) _____			
Neurological Symptoms (rare) If yes, _____ (symptom)		Severity ____	

<input type="checkbox"/> impaired consciousness			
<input type="checkbox"/> lethargy <input type="checkbox"/> restlessness			
3.1 Medications for dengue			
Has the patient taken any medications for dengue? <input type="checkbox"/> yes <input type="checkbox"/> no			
If yes, _____ (drug) _____ (dose) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (date, dd/mm/yy)			
_____ (drug) _____ (dose) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (date, dd/mm/yy)			
_____ (drug) _____ (dose) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (date, dd/mm/yy)			
Was the patient administered parenteral fluid? <input type="checkbox"/> no <input type="checkbox"/> yes			
If 'yes': <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ml For maintenance only? <input type="checkbox"/> yes Type: _____			
For rehydration? <input type="checkbox"/> yes (<i>crystalloid, colloid, blood, plasma, etc.</i>)			
For shock resuscitation? <input type="checkbox"/> yes			

4. Past Medical History (DK="don't know"). (NOTE: Please use a ✓)

Medical condition	YES	NO	DK	Medical condition	YES	NO	DK
Asthma				Seasonal or environmental allergies			
				<input type="checkbox"/> animals			
Diabetes				<input type="checkbox"/> dust			
				<input type="checkbox"/> mold			
Food allergy				<input type="checkbox"/> pollen			
<i>If yes, to what food?</i>				<input type="checkbox"/> other, _____			
_____				<input type="checkbox"/> Don't know allergen			
Allergy to insect bites				Chronic inflammatory disorder of the skin			
				<input type="checkbox"/> chronic urticaria			
				<input type="checkbox"/> eczema			
				<input type="checkbox"/> contact dermatitis			
				<input type="checkbox"/> psoriasis			
Drug allergy				Others			
<i>If yes, to what drug?</i>				<i>If 'Yes', please specify:</i>			
_____				_____			
Anaphylaxis requiring hospitalization or family history of anaphylaxis?				Inflammatory bowel disease			
If yes				<input type="checkbox"/> colitis			
<input type="checkbox"/> patient				<input type="checkbox"/> Crohn's disease			
<input type="checkbox"/> mother				<input type="checkbox"/> other, _____			
<input type="checkbox"/> father							
<input type="checkbox"/> grandparent							
<input type="checkbox"/> sibling							
Hospitalization due to dengue				Previous diagnosis of laboratory confirmed dengue?			

				<i>If yes, date(s) of diagnosis</i> _____			
				<i>If yes, location(s) of diagnosis</i> _____			

5. Baseline Measures

White Blood Count	_____	x10 ⁹ /L	<input type="checkbox"/> Not Collected
Serum Creatinine	_____	umol/L	<input type="checkbox"/> Not Collected
Hemoglobin	_____	g/dL	<input type="checkbox"/> Not Collected
Platelet Count	_____	x10 ⁹ /L	<input type="checkbox"/> Not Collected
RBC count	_____	x10 ¹² /L	<input type="checkbox"/> Not Collected
Neutrophil count	_____	x10 ⁹ /L	<input type="checkbox"/> Not Collected
Monocyte count	_____	x10 ⁹ /L	<input type="checkbox"/> Not Collected
Lymphocyte count	_____	x10 ⁹ /L	<input type="checkbox"/> Not Collected
Eosinophil count	_____	x10 ⁹ /L	<input type="checkbox"/> Not Collected
Basophil count	_____	x10 ⁹ /L	<input type="checkbox"/> Not Collected
Hematocrit	_____	%	<input type="checkbox"/> Not Collected
AST	_____	U/L	<input type="checkbox"/> Not Collected
ALT	_____	U/L	<input type="checkbox"/> Not Collected

6. Laboratory Confirmation of Dengue

PCR	NS1	IgM	IgG
<input type="checkbox"/> +ve <input type="checkbox"/> -ve <input type="checkbox"/> ND	<input type="checkbox"/> +ve <input type="checkbox"/> -ve <input type="checkbox"/> ND	<input type="checkbox"/> +ve <input type="checkbox"/> -ve <input type="checkbox"/> ND	<input type="checkbox"/> +ve <input type="checkbox"/> -ve <input type="checkbox"/> ND

7. Return Visit Questionnaire (Study Day 4-5) (DK="don't know")

Today's Date []/[]/[] dd/mm/yy

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Diarrhoea <i>If yes, number of episodes</i> ____			
Muscle pain		Severity ____	
Joint pain		Severity ____	
Retroorbital pain		Severity ____	
Rash		Severity ____	

<i>If yes, please indicate below:</i> <input type="checkbox"/> maculopapular <input type="checkbox"/> erythematous			
Headache		Severity ____	
Conjunctivitis		Severity ____	
Bleeding <i>If yes, please indicate below:</i> <input type="checkbox"/> gums <input type="checkbox"/> nose <input type="checkbox"/> Ecchymosis <input type="checkbox"/> epistaxis <input type="checkbox"/> GI <input type="checkbox"/> petechiae <input type="checkbox"/> Vaginal <input type="checkbox"/> other, _____ <input type="checkbox"/> Urinary tract			
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_____ (drug) _____ (dose) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> (date, dd/mm/yy)			

