TEXAS Department of State Health Services

Enterovirus D68 (EV-D68) Infections
Patient Under Investigation Short Form

Local health departments should submit this report to the regional health department.
Regional health departments should fax this report to 512-776-7616.

Patient's Name:	**Address:**	**City:**	**County:**	**Zip code:**
Date of Birth:	**Home Phone:**	**Cell Phone:**	**Email:**	

Date of Report:	**Reporter's Name:**	**Reporter's Agency:**	**Reporter's Phone/Email:**
Investigation Start Date:	**Investigator's Name:**	**Investigator's Agency:**	**Investigator's Phone/Email:**
Hospital/Healthcare Facility Name:	**Healthcare Facility Address:**		**Patient Hospital ID/MR#:**
Physician's Name:	**Physician's Contact Information:**		**State Specimen ID:**

Patient Sex: ☐M ☐F **Age**: _____ ☐Months ☐Years **Patient's State of Residence** _____

Race: ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐American Indian or Alaska Native ☐White
Ethnicity: ☐Hispanic ☐Non-Hispanic

Date of symptom onset: _____

Symptoms *(mark all that apply)*: ☐Fever / Highest recorded temperature _____ (°F / °C) ☐Chills ☐Cough ☐Wheezing
☐Sore throat ☐Runny nose ☐Shortness of breath / difficulty breathing ☐Tachypnea ☐Retractions ☐Cyanosis ☐Vomiting
☐Diarrhea ☐Rash ☐Lethargy ☐Seizure ☐Other (describe): _____

Does the patient have any comorbid conditions? *(mark all that apply)*: ☐None ☐Unknown ☐Asthma ☐Reactive airway disease
☐Bronchopulmonary dysplasia ☐Cardiac disease ☐Immunocompromised ☐Prematurity, if yes, gestational age_____
☐Other (describe): _____

Abnormal chest radiograph? ☐Yes ☐No ☐Unknown **Abnormal chest CT?** ☐Yes ☐No ☐Unknown

		Yes	No	Unknown
Is/Was the patient:	Hypoxic (sat <93%) on room air?			
	Treated with supplemental oxygen?			
	Treated with bronchodilators?			
	Treated with antibiotics?			
	Hospitalized? If Yes, *admission date*: _____ *Discharge date:*_____			
	If Yes, was the patient admitted to an Intensive Care Unit (ICU)?			
	If Yes, was the patient placed on non-invasive ventilation (BiPAP/CPAP)?			
	If Yes, was the patient intubated?			
	If Yes, was the patient placed on ECMO?			
Did the patient die?	If Yes, *date of death*: _____			

General Pathogen Laboratory Testing (*mark all that apply*)

Pathogen	Pos	Neg	Pending	Not Done	Pathogen	Pos	Neg	Pending	Not Done
Influenza A PCR					Rhinovirus and/or Enterovirus				
Influenza B PCR					Coronavirus (seasonal)				
Influenza Rapid Test					*Chlamydophila pneumoniae*				
RSV					*Mycoplasma pneumoniae*				
Human metapneumovirus					*Legionella pneumophila*				
Parainfluenza virus					*Streptococcus pneumoniae*				
Adenovirus					Blood culture ☐Yes ☐No If positive, which bacteria_____				
Other: _____					CSF culture ☐Yes ☐No If positive, which bacteria_____				
Other: _____					Sputum culture ☐Yes ☐No If positive, which bacteria_____				

Enterovirus Typing - Specimen Type	Date Collected	Specimen ID	Enterovirus Typing - Specimen Type	Date Collected	Specimen ID
NP OP NP/OP (*circle one*)			Bronchoalveolar lavage (BAL)		
Nasal wash / aspirate			Tracheal Aspirate		
Sputum			Stool/Rectal swab		
Other: _____			Other: _____		

To be completed by CDC: ***Patient ID: _____*** ***CSID: _____*** ***CSID: _____***

CSID: _____ ***CSID: _____*** ***CSID: _____***