ATTENTION

The District of Columbia Department of Health is requesting that health care facilities no longer submit handwritten, faxed Zika case report forms, but use our online submission system, which is found on our website: http://doh.dc.gov/page/providers-information-zika-virus-testing-district-columbia. Please try to transition to using the online form. Thank you for your cooperation.

Government of the District of Columbia
Department of Health
Communicable Disease Report Form

Center for Policy, Planning, and Evaluation
Division of Epidemiology-Disease Surveillance & Investigation (DE-DSI)

Final Dx:_____ MMWR Wk _____ MMWR Yr _____
Investigation ID:_____ Patient ID:_____ ☐ Confirmed ☐ Probable
☐ Suspect ☐Transfer ☐ Not a case

THIS BOX FOR DC DOH USE ONLY

NOTE: This form should be used for all reportable conditions EXCEPT the following: HIV, Tuberculosis, Hepatitis B,C, and STDs

Clinical/Suspected Diagnosis: _____ Date: _____

Outcome: ☐ Survived ☐ Deceased (if deceased, date):_____

*Submitter Name	*Affiliation/Organization	Phone	Fax Number

Submitter Email	☐ Hospital ☐ Laboratory ☐ Clinic ☐ School/Daycare

PATIENT INFORMATION

*Last Name:_____ *First Name:_____ Birth Date:_____
MRN:_____ *Home Phone:_____ Email:_____
Address:_____ *City:_____ *State:_____ *Zip:_____
Occupation:_____ ☐ Food Handler ☐ Child Caregiver ☐ Health care worker
School/Daycare Attends: _____ Sex: ____ Male ____ Female
*Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American/Alaskan ☐ Unknown
Ethnicity: ☐ Hispanic ☐ Non-Hispanic Household contacts: names/ages:_____
If patient is a minor, name of Parent(s)/guardian(s):_____
Recent Travel History (Location/dates): _____

CLINICAL INFORMATION ☐ Acute illness ☐ Chronic Illness Patient notified of lab result? ☐ Yes ☐ No
Date of visit: _____ Admitted? ☐ Yes ☐ No Discharge Date:_____
Name of health care provider patient seen by:_____ Email:_____
Past Medical History_____ Symptom onset date:_____
Symptoms:_____ Symptom Duration:_____
Referred to/Follow-up:_____

DIAGNOSTIC TESTING

*Collection date	*Specimen Type	Test	Result Date	Result

*Drug resistant: ☐ Yes# ☐ No ☐ Unknown/Not tested
#If Yes, resistant drugs:_____ **(Please include the laboratory results with this form)**

TREATMENT

Date Started	Drug	Dose	Route	Frequency	Duration

Additional Comments

Please Fax this Form to DE-DSI: (202) 442-8060

Government of the District of Columbia
Department of Health
Zika Case Report Form
November 22, 2016

TRAVEL EXPOSURE

1. Patient traveled to Zika-affected area in past 3 months? ☐ Yes ☐ No

PATIENT	Destination 1	Destination 2
Destination (include city if known)		
Date arrived to Zika-affected area		
Date departed from Zika-affected area		

2. Any other travel to the Caribbean, Central America, South America, or Mexico during the last 2 years **(excluding most recent travel)**? ☐ Yes ☐ No
   a) Please describe:_____

SEXUAL EXPOSURE

3. Patient had sex without a condom with someone who traveled to or resides in a Zika-affected area? ☐ Yes ☐ No
   a) Date of most recent sex without a condom (includes anal, oral, and vaginal sex):
   b) Type of most recent sex without a condom: ☐ Vaginal ☐ Anal ☐ Oral

4. Did the patient's sexual partner travel with the patient? ☐ Yes ☐ No
   If **NO**, please describe the partner's travel below:

PARTNER	Destination 1	Destination 2
Destination (include city if known)		
Date arrived to Zika-affected area		
Date departed from Zika-affected area		

5. Sexual partner had symptoms within 2 weeks of return from Zika-affected area? ☐ Yes ☐ No
   a) If **YES**, did the sexual partner experience the following: ☐ Fever ☐ Conjunctivitis ☐ Rash ☐ Joint pain (arthralgia)
   b) Sexual partner's symptom onset date:_____

OTHER EXPOSURES/PREGNANCY INFORMATION

Additional details about patient's potential Zika exposure:

6. Pregnancy status at the time of travel: ☐ Not pregnant ☐ Pregnant/conceived during travel ☐ Conceived after travel

a) Gestational age (weeks) at the time of travel:	
b) Date of last menstrual period:	
c) Estimated due date:	
d) Current gestational weeks:	
e) Date of most recent ultrasound	
f) Any fetal abnormalities? (If yes, describe)	

CLINICAL INFORMATION

7. Patient experienced any symptoms? ☐ Yes ☐ No
   a) If **YES**, please describe symptoms and date of onset on the next page:

Government of the District of Columbia
Department of Health
Zika Case Report Form

November 22, 2016

	Yes	No	Date of Onset
Fever			
☐ Subjective ☐ Measured (*indicate the max temperature:*) _____			
Rash			
Pruritic?			
☐ Macular ☐ Papular ☐ Petechial ☐ Purpuric ☐ Other			
Describe rash distribution:			
	Yes	**No**	**Date of Onset**
Conjunctivitis			
Joint pain			
Headache			
Sore throat			
Cough			
Myalgia			
Vomiting			
Diarrhea			
Chills			
Hemorrhagic manifestation			
Nasal bleed			
Bleeding gums			
Blood in urine			
Vaginal bleed (*for women*)			
Hematospermia (*for men*)			

b) Please describe any additional symptoms:

c) Any other sick contacts in patient's household that did not travel? ☐ Yes ☐ No

8. Travel-Associated Vaccination History

Vaccine	Received? (yes, no, or unknown)	Date Received
Yellow fever		
Japanese Encephalitis		
Tickborne Encephalitis		

9. Patient donated or received blood products in the past year? ☐ Yes ☐ No

10. Are any of the following diagnoses being considered (check all the apply)

Acute flaccid paralysis ☐
Aseptic Meningitis ☐
Guillain-Barre Syndrome ☐
None of the above ☐

11. Is this test request: ☐ New test request ☐ Additional test request for a patient previously tested
Previous Zika test was through DC DOH? ☐ Yes ☐ No ☐ Unknown **Previous Zika ID#:**

12. Other relevant information: