

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	<input type="checkbox"/> Hospital <input type="checkbox"/> Laboratory <input type="checkbox"/> Clinic <input type="checkbox"/> 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: | <input style="width: 300px; height: 20px;" type="text"/> |
| b) Date of last menstrual period: | <input style="width: 300px; height: 20px;" type="text"/> |
| c) Estimated due date: | <input style="width: 300px; height: 20px;" type="text"/> |
| d) Current gestational weeks: | <input style="width: 300px; height: 20px;" type="text"/> |
| e) Date of most recent ultrasound | <input style="width: 300px; height: 20px;" type="text"/> |
| f) Any fetal abnormalities? (If yes, describe) | <input style="width: 300px; height: 20px;" type="text"/> |

CLINICAL INFORMATION

7. Patient experienced any symptoms? Yes No

a) If **YES**, please describe symptoms and date of onset on the next page:

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Department of Health
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November 22, 2016

		Yes	No	Date of Onset
Fever				
<input type="checkbox"/> Subjective		<input type="checkbox"/> Measured (<i>indicate the max temperature:</i>) _____		
Rash				
		Pruritic?		
<input type="checkbox"/> Macular		<input type="checkbox"/> Papular	<input type="checkbox"/> Petechial	<input type="checkbox"/> Purpuric
<input type="checkbox"/> 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 (<i>for women</i>)				
Hematospermia (<i>for men</i>)				

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 nknown **Previous Zika ID#:**

12. Other relevant information:
