



**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: _____	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable
	<input type="checkbox"/> Suspect <input type="checkbox"/> Transfer <input type="checkbox"/> Not a case
<b>THIS BOX FOR DC DOH USE ONLY</b>	

**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<sup>#</sup>     No     Unknown/Not tested  
<sup>#</sup>If Yes, resistant drugs: \_\_\_\_\_ (Please include the laboratory results with this form)

**TREATMENT**

Date Started	Drug	Dose	Route	Frequency	Duration

**Additional Comments**

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



**Government of the District of Columbia**  
**Department of Health**  
 Updated: 2/25/2016



**Zika Virus Case Report Form**

1. Recent travel outside of the continental U.S.?      Yes      No
  - a. Date left US:
  - b. Destination/Places visited (*with travel dates*):
  - c. Date returned to US:

2. Symptoms (*please complete the chart below*):

Date of Individual Symptom Onset:	Yes	No	Date of Onset:
Fever:			
<input type="checkbox"/> Subjective <input type="checkbox"/> Measured ( <i>indicate the max temperature</i> ) _____ <input type="checkbox"/> Lasting 4 – 7 days			
<b>Symptoms</b>			
Rash ( <i>if yes indicate if pruritic, type, and distribution</i> ):			
Pruritic:			
<input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Other Describe Distribution:			
Eye Symptoms:			
Non-purulent conjunctivitis:			
Eye pain:			
Myalgia:			
Headache:			
Chills:			
Joint Pain:			
Persistent vomiting:			
Oral Ulcers:			
Diarrhea:			
Peripheral edema:			
Cough:			
Sore throat:			
<b>Any Hemorrhagic Manifestation</b>			
Nasal bleed:			
Bleeding Gums:			
Blood in urine:			
Vaginal bleed ( <i>for women</i> ):			
Hemospermia ( <i>for men</i> ):			

3. Reason for visiting doctor?



4. Took malaria prophylaxis?      Yes      No

a. Which prophylaxis?

i. Date started:

ii. Date ended:

5. Pregnant at time of exposure?      Yes      No

a. If yes how far along is the pregnancy (*during travel*)?

b. Due Date?

c. Complications?

d. Date of last Ultrasound?                      Result:

e. First pregnancy?      Yes      No

6. Person(s) traveling with patient?      Yes      No

a. Names

i. Ages

ii. Relationship to patient

b. Symptoms of person traveling with patient (*if applicable*):

c. Symptom onset date of person traveling with patient (*if applicable*):

7. Any other sick contacts in patient's household that were not traveling?      Yes      No

8. History of living outside the united states:

<i>Country</i>	<i>Dates</i>

9. History of traveling to the Caribbean, Central America, South America, or Mexico during last 2 years?

10. Travel Associated Vaccination History:

<i>Vaccine</i>	<i>Date Given</i>
Yellow Fever	
Japanese Encephalitis	
Tick Borne Encephalitis (TBE)	
Other	

11. Other pertinent information not already listed (*if applicable*):