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
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Updated: 8/04/2016

Zika Case Report Form

1. Recent travel to a Zika-affected area? Yes ☐ No ☐ If no, did the patient's partner travel? ☐ Yes ☐ No

Date left U.S./traveled to Zika-affected area	
Destination(s)/Place(s) visited (*with travel dates*):	
Date returned from Zika-affected area:	

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

Date of Individual Symptom Onset:	Yes	No	**Date of Onset:**
Fever:			
☐ Subjective ☐ Measured (*indicate the max temperature*) _____ ☐ Lasting 4 – 7 days			
Symptoms			
Rash (*if yes indicate if pruritic, type, and distribution*):			
Pruritic:			
☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ 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			
Any Hemorrhagic Manifestation			
Nasal bleed			
Bleeding gums			
Blood in urine			
Vaginal bleed (*for women*)			
Hematospermia (*for men*)			

3. Reason for visiting doctor?

4. Took malaria prophylaxis? ☐ Yes ☐ No
   a. Which prophylaxis?
      i. Date started:
      ii. Date ended:
5. Patient currently pregnant? ☐ Yes ☐ No
   a. If yes, how far along at time of travel (# weeks):
   b. **If the patient was not pregnant at the time of travel, did they conceive within 8 weeks of the date they returned from travel?** Yes ☐ No ☐ If yes, date of last menstrual period:
   c. Due Date:
   d. Complications?
   e. Date of last Ultrasound: Result:
   f. First pregnancy? ☐ Yes ☐ No

6. Additional people traveled with patient? ☐ Yes ☐ No

Name	*Relationship to patient*	*Age*	*Experienced any symptoms? If yes, please describe*	*Symptom onset date (if applicable)*

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

8. History of living outside the United States? ☐ Yes ☐ No

Country	*Dates*

9. History of traveling to the Caribbean, Central America, South America, or Mexico during last 2 years (excluding most recent travel):

10. Travel Associated Vaccination History:

Vaccine	*Received? (yes, no, or unknown)*	*Date Received*
Yellow Fever		
Japanese Encephalitis		
Tick Borne Encephalitis (TBE)		
Other		

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