



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): _____

Table with 4 columns: *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

Table with 5 columns: *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

Table with 6 columns: Date Started, Drug, Dose, Route, Frequency, Duration

Additional Comments

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



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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 (<i>with travel dates</i>):	
Date returned from Zika-affected area:	

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			
Symptoms			
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			
Any Hemorrhagic Manifestation			
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. 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):