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:_____
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

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Updated: 2/5/2016

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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 U.S.:

2. Date of symptom onset (*please indicate below the signs and symptoms that the patient had at the time of illness*):

Date of Individual Symptom Onset:	Yes	No	Don't know
Fever lasting 4-7 days			
Fever(>38°C/100.4 F)			
Symptoms			
Maculopapular Rash			
Non-purulent conjunctivitis			
Myalgia			
Headache			
Rapid, weak pulse			
Pallor or cool skin			
Chills			
Eye pain			
Joint Pain			
Anorexia			
Persistent vomiting			
Abdominal pain			
Liver enlargement > 2cm			
Diarrhea			
Cough			
Sore throat			
Convulsion/coma			
Any Hemorrhagic Manifestation			
Nasal bleed			
Bleeding Gums			
Blood in urine			
Vaginal bleed			
Other			

    a. Reason for visiting doctor?

3. On malaria prophylaxis? Yes No
    a. Which prophylaxis?
        i. Date started:
        ii. Date ended:
4. Pregnant at time of exposure? Yes No
    a. If yes how far along is the pregnancy (*during travel*)?
    b. Due Date?
    c. Complications?
    d. First pregnancy?
5. 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*):
6. Any other sick contacts in patient's household that were not traveling? Yes No
7. History of living outside the united states:

Country	*Dates*

8. History of traveling to the Caribbean, Central America, or South America during last 2 years?
9. Travel Associated Vaccination History:

Vaccine	*Date Given*
Yellow Fever	
Japanese Encephalitis	
Tick Borne Encephalitis (TBE)	

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