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	☐ 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
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:

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____

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:	
b) Date of last menstrual period:	
c) Estimated due date:	
d) Current gestational weeks:	
e) Date of most recent ultrasound	
f) Any fetal abnormalities? (If yes, describe)	

CLINICAL INFORMATION

7. Patient experienced any symptoms? ☐ Yes ☐ No
   a) If **YES**, please describe symptoms and date of onset on the next page:

899 North Capitol Street, N.E. • 5th Floor • Washington, D.C. 20002 • Phone (202) 442-9371 • Fax (202) 442-8060

	Yes	No	Date of Onset
Fever			
Subjective Measured (*indicate the max temperature:*) ________			
Rash			
Pruritic?			
☐ Macular ☐ Papular ☐ Petechial ☐ Purpuric ☐ 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 (*for women*)			
Hematospermia (*for men*)			

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. Other relevant information:

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