WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Zika Virus Disease and Zika Congenital Infection

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
Phone (home): _____ **Phone** (work/cell) : _____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: _____ *Phone*: _____

Birth date: __ / __ / ____ **Age**: _____
Sex: ☐Male ☐Female ☐Unk
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐ Native HI/Other PI ☐Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigation Start Date: __ / __ / ____
Earliest date reported to LHD: __ / __ / ____
Earliest date reported to DIDE: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other
Reporter Name: _____ Reporter Phone: _____
Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

☐Zika Virus Disease **(ZVD)**
☐Zika Congenital Infection **(ZCI)**

Clinical Findings

Y	N	U	
☐	☐	☐	Fever (Highest measured temperature: _____ °F)
☐	☐	☐	Rash
☐	☐	☐	Arthralgia
☐	☐	☐	Conjunctivitis
☐	☐	☐	Guillain-Barre syndrome not associated with other known etiology
☐	☐	☐	Microcephaly
☐	☐	☐	Intracranial calcifications
☐	☐	☐	Congenital nervous system abnormalities
☐	☐	☐	Other: _____

Clinical Risk Factors

Y	N	U	
☐	☐	☐	Underlying medical condition
☐	☐	☐	Immune suppression

Hospitalization

Y	N	U	
☐	☐	☐	Patient hospitalized for this illness

If yes, hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Death

Y	N	U	
☐	☐	☐	Patient died due to this illness

If yes, date of death: __ / __ / ____

VACCINATION HISTORY

Y	N	U	
☐	☐	☐	Ever vaccinated for yellow fever (If yes, date: __ / __ / _____)
☐	☐	☐	Ever vaccinated for Japanese encephalitis (If yes, date: __ / __ / ____)
☐	☐	☐	Ever vaccinated for tickborne encephalitis (If yes, date: __ / __ / ____)

LABORATORY *(Please submit copies of <u>all</u> labs, including CSF studies associated with this illness to DIDE)*

Y	N	U	
☐	☐	☐	Detection of Zika virus or Zika virus-specific nucleic acids from specimens of serum, CSF, urine, semen, amniotic fluid, saliva, or tissue
☐	☐	☐	Detection of Zika virus antigen by immunohistochemical staining of tissue specimen
☐	☐	☐	Detection of Zika virus IgM antibodies in serum or CSF

NOTES

INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period

	Exposure period		Onset date
Days from onset	_____ *(Enter Max Incubation)**	_____ *(Enter Min Incubation)**	
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

EPIDEMIOLOGIC EXPOSURES (based on the above exposure period, unless otherwise specified)

Y N U

☐ ☐ ☐ History of travel within 14 days of illness onset (if yes, complete travel history below):

Travel Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for travel

Y N U

☐ ☐ ☐ Travel to country or region with active Zika virus transmission
☐ ☐ ☐ Pregnant during travel country or region with active Zika virus transmission
☐ ☐ ☐ Sexual contact with a person with laboratory confirmed or probable Zika virus infection
☐ ☐ ☐ Association in time and place with a person with laboratory confirmed or probable Zika virus infection

Y N U

☐ ☐ ☐ Artificial water-holding containers present near residence
☐ ☐ ☐ Areas of standing water present near residence
☐ ☐ ☐ Hardwood forest present near residence
☐ ☐ ☐ Poorly draining gutters present near residence
☐ ☐ ☐ Window/door screens in disrepair or missing at residence

Geographic coordinates of patient residence:
Latitude: _____ Longitude: _____
(Indicate units:
☐Decimal Degrees ☐Degrees Minutes Seconds ☐Other)

Y N U

☐ ☐ ☐ Blood transfusion 30 days prior to onset (Date:__/__/____)
☐ ☐ ☐ Organ transplant 30 days prior to onset (Date:__/__/____)
☐ ☐ ☐ Case was prenatally exposed (in utero)
☐ ☐ ☐ Case is a breast-fed infant
☐ ☐ ☐ Outdoor recreational activities (e.g. hiking, camping, etc)
☐ ☐ ☐ Mosquito bite

☐ ☐ ☐ Possible occupational exposure
☐ Laboratory worker (Date of exposure:__/__/____)
☐ Other occupation: _____

Where did exposure most likely occur? **County: _____ State:_____ Country: _____**

PUBLIC HEALTH ISSUES

Y N U

☐ ☐ ☐ Case identified through blood donor screening
☐ ☐ ☐ Case donated blood products, organs or tissue in the 30 days prior to symptom onset
Date:__/__/____
Agency/location:_____
Type of donation:_____
☐ ☐ ☐ Case is pregnant (Due date: __/__/____)
☐ ☐ ☐ Case knows someone who had shared exposure and is currently having similar symptoms
☐ ☐ ☐ Epi link to another confirmed case of same condition
☐ ☐ ☐ Case is part of an outbreak
☐ ☐ ☐ Other:

PUBLIC HEALTH ACTIONS

Y N U

☐ ☐ ☐ Notify blood or tissue bank or other facility where organs donated
☐ ☐ ☐ Notify patient obstetrician
☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian
☐ ☐ ☐ Recommended environmental measures to patient/family to reduce risk around home
☐ ☐ ☐ Education or outreach provided to employer
☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a shared exposure
☐ ☐ ☐ Patient is lost to follow-up
☐ ☐ ☐ Other:

WVEDSS

Y N U

☐ ☐ ☐ Entered into WVEDSS (**Entry date**: __ / __ / ____) **Case Status:** ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

NOTES

*Incubation Period = 2-7 days