Congenital Zika Virus Report Form

Department of Public Health
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P.O. Box 340308
Hartford, CT 06134-0308

(Complete and fax this form to 860-509-7910. For questions, call 860-509-7994.)

Infant Information

Name (Last) (First) (MI)	**Birth Date**	**Gestation Age**

Ultrasound

Date 1: _____ Date 2: _____

Microcephaly ☐ Yes ☐ No — Microcephaly ☐ Yes ☐ No

If yes, percentile: _____ — If yes, percentile: _____

Intracranial calcifications ☐ Yes ☐ No — Intracranial calcifications ☐ Yes ☐ No

Other:_____ — Other:_____

Examination

Was an ophthalmologic exam performed? ☐ Yes ☐ No

If yes, result: _____

Was a hearing test performed? ☐ Yes ☐ No

If yes, result: _____

Clinical Findings Postnatal

Microcephaly ☐ Yes

Intracranial calcifications ☐ Yes

Other findings: _____

_____

Length: _____

Weight: _____

Head circumference: _____

Other testing: _____

Samples available for testing

☐ Cord blood
☐ Placenta fixed ☐ frozen ☐
☐ Serum
☐ Other: _____

Pediatrician: Name: _____ Phone: _____

Patient/Mother Information

Name (Last) (First) (MI) Parent or Guardian Name	**Age**	**Birth Date**	**Patient's Phone**

Address (No. and Street) (Apt. #) (City or Town) (State) (Zip Code)

Primary Language Spoken

☐ English ☐ Spanish ☐ Other: _____

Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Unknown

Hispanic/Latino
☐ Yes
☐ No
☐ Unknown

Is patient **pregnant**?

☐ Yes ☐ No ☐ Unknown

If yes, # of weeks: _____

Did mother **travel** to a Zika virus affected area during pregnancy?
☐ Yes ☐ No ☐ Unknown
If yes, country or countries visited: _____

Arrival date: _____ Departure date: _____

Did patient have **sexual contact** (with partner with travel history) during pregnancy?

☐ Yes ☐ No ☐ Unknown

Vaccination History (check all that apply)

☐ Yellow fever ☐ Japanese encephalitis virus

Obstetrician/Provider

Name: _____Phone:_____

Symptoms: Did mother have symptoms? ☐ Yes ☐ No If yes, onset date: _____

Fever: ☐ Yes ☐ No ☐ Unknown If yes, highest temp: _____ Onset date of temp: _____

Rash (maculopapular) ☐ Yes ☐ No ☐ Unknown **C**onjunctivitis: ☐ Yes ☐ No ☐ Unknown **A**rthralgia: ☐ Yes ☐ No ☐ Unknown

Tested: Was mother tested for Zika virus? ☐ Yes ☐ No if yes, ☐ IgM result: _____ ☐ PCR result: _____

Reporters Information

Reporting healthcare provider name and address	**Hospital Information**:	Date **Admitted**	Date **Discharged**
Direct phone: _____	Name: City: State:	**Patient ID #:**	

Name of person completing the form: _____ Address: _____

Phone: _____ FAX: _____ Report Date: _____

Laboratory Tests Performed »

Specimen[1]	Collection Date	Test[2]	Result
_____	_____	_____	_____
_____	_____	_____	_____

1 = e.g. serum, urine, placenta, etc.
2 = PCR, IgM, PRNT, etc.