Zika Virus Report Form

Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308

(Report by completing and faxing this form to 860-509-7910. For questions, call 860-509-7994.)

Patient Name (Last) (First) (MI)	Parent or Guardian Name	Age	Birth Date	Patient's Telephone Home Work Cell
Address (No. and Street) (Apt. #)	(City or Town) (State) (Zip Code)	(Primary Language Spoken) ☐ English ☐ Spanish ☐ Other: specify:_____		

Gender ☐ Male ☐ Female ☐ Other specify: _____ ☐ Unknown

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

Hispanic/Latino ☐ Yes ☐ No ☐ Unknown

Vaccination History ☐ Yellow fever ☐ Japanese encephalitis virus

Is patient pregnant? ☐ Yes ☐ No ☐ Unknown # of weeks: _____ Due date: _____
Ultrasound findings: _____ Date: _____
Ultrasound findings: _____ Date: _____

EPI-link

Did patient have recent travel to a Zika virus affected area? ☐ Yes ☐ No ☐ Unknown

If yes, country or countries visited:_____

Date of arrival: _____ Date of departure: _____

☐ Check if a Sentinel Surveillance System patient (*Applies to select clinics ONLY*)

Did patient have unprotected sexual contact with a person who traveled to an affected area in the prior 2 weeks? ☐ Yes ☐ No ☐ Unk.

Where did sexual partner travel: _____

Was sexual partner tested? ☐ Yes ☐ No ☐ Unk. If yes, was test positive? ☐ Y ☐ N ☐ U

Did patient receive a blood product within 30 days of symptom onset? ☐ Yes ☐ No ☐ Unk.

Did patient receive organ transplant within 30 days of symptom onset? ☐ Yes ☐ No ☐ Unk.

SYMPTOMS

Did patient have symptoms? ☐ Yes ☐ No ☐ Unknown
if yes, check all that apply:

Primary Symptoms	**Symptom onset date**: _____		
Fever	☐ Yes	☐ No	☐ Unknown
If yes, temp: _____	temp date of onset: _____		
Rash (maculopapular)	☐ Yes	☐ No	☐ Unknown
Arthralgia	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown
Guillain–Barré syndrome not known to be associated with another diagnosed etiology?	☐ Yes	☐ No	☐ Unknown
Secondary Symptoms			
Fatigue	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Orbital pain	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown
Vomiting	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown

Reporting healthcare provider name and address:

Direct telephone

_____

If hospitalized, **hospital**:	Date Admitted	Date Discharged
Name City State	Patient ID #	

Name of person completing report: _____

Address:_____

Phone: _____ FAX: _____ Report Date: _____

Laboratory Tests Performed

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

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