ZIKA INVESTIGATION FORM
CONGENITAL INFECTION OR DISEASE

PATIENT INFORMATION

Parents Name or Proxy, if applicable: _____

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Sex: ☐ Female ☐ Male ☐ Unknown

Race (**SELECT ALL THAT APPLY**): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown Country of Birth: _____

Is the patient deceased? ☐ No ☐ Yes ☐ Unknown Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Country of Usual Residence: _____ Dwelling Type: ☐ Duplex ☐ Mobile Home ☐ Multi-unit ☐ Office ☐ Single Family

Does the building have screens on **ALL** the windows: ☐ No ☐ Yes ☐ Unknown

Describe the air conditioner in this building (**SELECT ALL THAT APPLY**): ☐ Central Air ☐ Window Unit ☐ None

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: _____

ALTERNATE ADDRESS

Does the patient have an alternate residence (beach house, condo, lake house, dorm, etc.): ☐ No ☐ Yes ☐ Unknown

Alternate Street Address 1: _____ Alternate Street Address 2: _____

Alternate City: _____ Alternate County: _____ Alternate State:_____

Alternate Country: _____ Alternate Dwelling Type: ☐ Duplex ☐ Mobile Home ☐ Multi-unit ☐ Office ☐ Single Family

Does the building have screens on ALL the windows: ☐ No ☐ Yes ☐ Unknown

Describe the air conditioner in this building (**SELECT ALL THAT APPLY**): ☐ Central Air ☐ Window Unit ☐ None\

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigator:_____

Date Assigned to Investigation:_____ Date of Initial Interview Attempt: _____

Date ADPH Investigator provided patient, or patient representative, with Control Measures: _____

Education of Case/Contact: ☐ No ☐ Yes ☐ Not Applicable

If control measures were not provided, explain: _____

_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____ Type:_____

Reporting Organization: _____ Reporting Provider: _____

TREATMENT & OUTCOME

Physician Name: _____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes, hospital:_____

Admission Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐ days ☐ months ☐ years ☐ unknown

Illness Duration: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ weeks ☐ years ☐ unknown

Did patient die as a result of (or complication from) arboviral infection? ☐ No ☐ Yes ☐ Unknown Date of Death: __ __ / __ __ /__ __ __ __

CLINICAL

Did the infant have any of the following symptoms:

Signs & Symptoms

Any reported Fever or Chills? ☐ No ☐ Yes ☐ Unknown Highest temperature in °F: _____

Arthralgia or Arthritis (Joint Pain): ☐ No ☐ Yes ☐ Unknown Conjunctivitis (Pink Eye): ☐ No ☐ Yes ☐ Unknown

Rash: ☐ No ☐ Yes ☐ Unknown Describe the rash: _____

Describe the distribution of the rash: _____

Myalgia: ☐ No ☐ Yes ☐ Unknown Guillain-Barre syndrome: ☐ No ☐ Yes ☐ Unknown

Other neurological (e.g. seizures, paralysis, altered mental status): ☐ No ☐ Yes ☐ Unknown

Clinical Syndrome (SELECT ALL THAT APPLY):

☐ Asymptomatic (i.e., no fever or symptoms) ☐ Encephalitis/Meningoencephalitis ☐ Disease
☐ Uncomplicated Fever (only fever) ☐ Meningitis ☐ Other Clinical ☐ Unknown

RISK FACTORS

Blood

Was the patient identified by blood donor screening? ☐ No ☐ Yes ☐ Unknown

Has this patient donated blood within **30 days** of illness onset? ☐ No ☐ Yes ☐ Unknown Donation Date: __ __ / __ __ /__ __ __ __

Has this patient received a blood transfusion within **30 days** of illness onset? ☐ No ☐ Yes ☐ Unknown

Organ

Has the patient donated an organ within **30 days** of illness to onset? ☐ No ☐ Yes ☐ Unknown

Has the patient received an organ transplant within **30 days** of illness onset? ☐ No ☐ Yes ☐ Unknown

Infant

Is the patient a breast fed infant/child? ☐ No ☐ Yes ☐ Unknown

TRAVEL

Did the infant travel outside of county of residence prior to illness onset or Zika consultation: ☐ No ☐ Yes ☐ Unknown

If Yes, please complete the table below:

Type of travel (in state, out of state, out of country)	Destination of travel (county, state, or country)	Name and address of destination	Travel Start Date	Travel End Date

Has the infant traveled or planning to travel 2 weeks post symptom onset or exposure: ☐ No ☐ Yes ☐ Unknown

If Yes, please complete the table below:

Type of travel (in state, out of state, out of country)	Destination of travel (county, state, or country)	Name and address of destination	Travel Start Date	Travel End Date

List all infant activities in the month since illness onset or potential Zika exposure if asymptomatic: (**excluding home activities**)

Outdoor Activity (e.g. gardening, swimming, walking)	Location name	Location Address

To your knowledge, has the infant ever been bitten by mosquitos: ☐ No ☐ Yes ☐ Unknown

Does the infant use mosquito repellent frequently: ☐ No ☐ Yes ☐ Unknown

Did the patient stay or will they stay at the alternate residence 2 weeks post onset or exposure: ☐ No ☐ Yes ☐ Unknown

Transmission Mode: ☐ Vector borne ☐ Sexually Transmitted ☐ Trans-placental transmission ☐Other

Was the patient infected in utero: ☐ No ☐ Yes ☐ Unknown

CLOSE CONTACT INFORMATION

Last Name:________________________________ First Name:_______________________________ Last Exposure Date: ___________________

DOB: __ __ / __ __ /__ __ __ __ Age: _______ ☐ years ☐ months

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: ________________________________

Type of Contact* (**SELECT ALL THAT APPLY**): ____

Last Name:________________________________ First Name:_______________________________ Last Exposure Date: ___________________

DOB: __ __ / __ __ /__ __ __ __ Age: _______ ☐ years ☐ months

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: ________________________________

Type of Contact* (**SELECT ALL THAT APPLY**): ____

Last Name:________________________________ First Name:_______________________________ Last Exposure Date: ___________________

DOB: __ __ / __ __ /__ __ __ __ Age: _______ ☐ years ☐ months

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: ________________________________

Type of Contact* (**SELECT ALL THAT APPLY**): ____

*Acquaintance, Child, Child Care Provider/Babysitter, Classmate, Co-Passenger, Co-Worker, Custodian/Guardian, Customer, Employee, Employer, Extended Family, Friend, Health Care Provider (Caregiver), Immediate Family, Mother, Neighbor, Other, Owner, Partner, Patient, Professional Service Provider, Roommate/Household Member, Sexual Contact, Spouse, Unknown, Veterinarian

SUPERVISOR REVIEW (PHA 4)

Date Due: __ __ / __ __ /__ __ __ __ Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):____

GENERAL COMMENTS

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