

ZIKA INVESTIGATION FORM

NON-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

PATIENT OCCUPATION INFORMATION

Patient Employer Name: _____

Primary Occupation: _____ Industry: _____

Street Address 1: _____ Street Address 2: _____

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

Country: _____

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

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 product 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 pregnant? No Yes Unknown

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

Occupation

Does the patient work with arboviral agents in a laboratory? No Yes Unknown

TRAVEL

Did the patient 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 patient 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

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List all patient 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

Does the patient recall ever being bitten by mosquitos: No Yes Unknown

Does the patient use mosquito repellent consistently: 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

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

EPIDEMIOLOGIC

Where was the disease acquired? Indigenous (within county) In State (out of county) Out of Country Out of State Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: Confirmed Probable Not a Case Suspect Unknown MMWR Week: _____ MMWR Year: _____

Select "Yes" only if case meets Confirmed or Probable Case Status: Is this case report published in ArboNET? Yes No

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

