

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

ZIKA CASE REPORT

Check one: Zika virus infection Unspecified flavivirus infection

Please note: Prompt, standardized interview of all cases of Zika is strongly encouraged to improve the accuracy of recall of possible sources of infection. Jurisdictions that choose to use this form should send completed forms to the Surveillance and Statistics Section by mail through your communicable disease reporting staff. For jurisdictions participating in CalREDIE, entry of information into the CalREDIE form will facilitate investigations and surveillance.

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence		Apartment/Unit Number		Ethnicity (check one)	
City/Town		State	Zip Code	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Census Tract	County of Residence	Country of Residence		Race* (check all that apply, race descriptions on page 6)	
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		<input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply)	
Home Telephone	Cellular Phone/Pager	Work/School Telephone		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Thai <input type="checkbox"/> Hmong <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____	
E-mail Address		Other Electronic Contact Information			
Work/School Location		Work/School Contact			
Gender					
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 6)		Other Describe/Specify			
Occupation (see list on page 6)		Other Describe/Specify			
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

First three letters of patient's last name:

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SIGNS AND SYMPTOMS										
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)				Date First Sought Medical Care (mm/dd/yyyy)				
Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted	Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Fever				<i>Highest temperature (specify °F/°C)</i>	Diarrhea					
Rash				<i>Description of rash</i>	Chills					
Conjunctivitis					Cough					
Joint pain				<i>Joint(s)</i>	Abdominal pain					
Muscle pain					Fatigue					
Headache					Bloody semen					
Nausea or vomiting					Oral ulcers					
<i>Other symptom (specify)</i>										
Does patient have suspected Guillain-Barre Syndrome or weakness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk										
If yes...										
Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted		Date of lumbar puncture: (mm/dd/yyyy)				
Weakness				<i>If yes, is it symmetric?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If yes, is it progressive?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	CSF Protein (highest) _____				
Paralysis						CSF White Blood Cell Count (highest) _____				
Diminished reflexes						Date of onset of neurologic symptoms: (mm/dd/yyyy)				
<i>Other potential causes of Guillain-Barré syndrome:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk (if yes, please specify below)										
<input type="checkbox"/> Vaccine _____ <input type="checkbox"/> Other febrile illness _____ <input type="checkbox"/> Diarrheal illness _____ <input type="checkbox"/> Other _____										
<i>If yes, date of symptom onset/vaccine: (mm/dd/yyyy)</i>										
Is patient a newborn? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk										
If yes...										
Vital Status	<input type="checkbox"/> Live birth <input type="checkbox"/> Fetal loss <input type="checkbox"/> Born alive and died <input type="checkbox"/> Unk <i>(If fetal loss, please attach any autopsy results and/or tissue studies)</i>									
Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted		Gestational age at birth _____ weeks Dating by: <input type="checkbox"/> Obstetrical estimate <input type="checkbox"/> Last menstrual period <input type="checkbox"/> Ultrasound <input type="checkbox"/> Newborn examination				
Microcephaly										
Intracranial calcifications						Head circumference at birth _____ cm _____ percentile				
Newborn hearing screen abnormal						Length at birth _____ cm _____ percentile				
Newborn eye exam abnormal						Birthweight _____ grams _____ percentile				
<i>Brain imaging results:</i>										
<i>Eye examination findings:</i>										
<i>Maternal history: Did mother experience symptoms of Zika during pregnancy?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk										
<i>Was mother tested for Zika virus?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk (If yes, include test results in notes section below)										
<i>If yes, did mother test positive for Zika virus?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk										

Continued on page 3

First three letters of patient's last name:

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If patient is PREGNANT:

<p>Has a fetal ultrasound been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk (If Yes, please attach all ultrasound reports)</p>	<p>If yes, fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Microcephaly <input type="checkbox"/> Intracranial calcifications <input type="checkbox"/> Other findings: _____</p> <p>If yes, dates of ultrasounds (mm/dd/yy) _____</p> <p>Gestational age at ultrasound _____ weeks</p>
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PAST MEDICAL HISTORY

<p>Has the patient been previously diagnosed with dengue? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p>If yes, date of diagnosis (mm/dd/yyyy)</p>
<p>Has the patient been vaccinated for yellow fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p>Has the patient been vaccinated for Japanese encephalitis virus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>
<p>Has the patient had a pregnancy complicated by suspected Zika infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk (Check all that apply) <input type="checkbox"/> Fetal loss <input type="checkbox"/> Perinatal death <input type="checkbox"/> Live birth <input type="checkbox"/> Microcephaly <input type="checkbox"/> Intracranial calcifications <input type="checkbox"/> Positive test for Zika infection <input type="checkbox"/> Other _____ (Please attach related results including MRI/CT scan, autopsy results)</p>	

HOSPITALIZATION

<p>Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p>Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p>If Yes, how many total hospital nights?</p>
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If there were any ER or hospital stays related to this illness, specify details below. Include hospital where delivery occurred for all infants and post-partum patients.

HOSPITALIZATION - DETAILS

Hospital Name 1	Street Address			Admission Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address			Admission Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

OUTCOME

<p>Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk</p>	<p>If Survived, Survived as of _____ (mm/dd/yyyy)</p>	<p>Date of Death (mm/dd/yyyy)</p>
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First three letters of patient's last name:

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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Laboratory type: State PH lab Local PH lab Commercial lab CDC lab Blood bank lab Other (specify): _____

Specimen Type 1 <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> CSF <input type="checkbox"/> Umbilical cord blood <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Other: _____	Type of Test <input type="checkbox"/> PCR <input type="checkbox"/> ELISA-IgM <input type="checkbox"/> IFA-IgM <input type="checkbox"/> NAT (blood bank) <input type="checkbox"/> PRNT <input type="checkbox"/> Other (specify): _____ <hr/> <table style="width: 100%;"> <tr> <td style="width: 50%;">Interpretation</td> <td style="width: 25%;">Results</td> <td style="width: 25%;">Collection Date (mm/dd/yyyy)</td> </tr> <tr> <td> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Indeterminate </td> <td></td> <td></td> </tr> </table> <hr/> <table style="width: 100%;"> <tr> <td style="width: 70%;">Laboratory Name</td> <td>Telephone Number</td> </tr> </table>	Interpretation	Results	Collection Date (mm/dd/yyyy)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Indeterminate			Laboratory Name	Telephone Number
Interpretation	Results	Collection Date (mm/dd/yyyy)							
<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Indeterminate									
Laboratory Name	Telephone Number								

Specimen Type 2 <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> CSF <input type="checkbox"/> Umbilical cord blood <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Other: _____	Type of Test <input type="checkbox"/> PCR <input type="checkbox"/> ELISA-IgM <input type="checkbox"/> IFA-IgM <input type="checkbox"/> NAT (blood bank) <input type="checkbox"/> PRNT <input type="checkbox"/> Other (specify): _____ <hr/> <table style="width: 100%;"> <tr> <td style="width: 50%;">Interpretation</td> <td style="width: 25%;">Results</td> <td style="width: 25%;">Collection Date (mm/dd/yyyy)</td> </tr> <tr> <td> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Indeterminate </td> <td></td> <td></td> </tr> </table> <hr/> <table style="width: 100%;"> <tr> <td style="width: 70%;">Laboratory Name</td> <td>Telephone Number</td> </tr> </table>	Interpretation	Results	Collection Date (mm/dd/yyyy)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Indeterminate			Laboratory Name	Telephone Number
Interpretation	Results	Collection Date (mm/dd/yyyy)							
<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Indeterminate									
Laboratory Name	Telephone Number								

Please list additional test results under Notes.

LABORATORY RESULTS SUMMARY - OTHER

Hematology	Date Collected (mm/dd/yyyy)	WBC	HCT	Hb	Platelets
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Other laboratory diagnostics performed (e.g., IHC, virus isolation)?			If Yes, describe		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: UP TO 14 DAYS BEFORE ILLNESS ONSET

BLOOD AND ORGAN DONATION (Please attach the Report of Zika Virus Positive Blood Donor form)

Did patient donate blood during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___	Did patient donate an organ during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___
Did patient receive a blood transfusion during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___	Did patient receive an organ transplant during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date: ___/___/___

TRAVEL HISTORY

Did patient travel outside of county of residence during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Has the patient traveled outside of California during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Has the patient traveled outside the U.S. during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes for any of these questions, specify all locations and dates below.

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

EXPOSURES / RISK FACTORS

Did patient recall any mosquito bites during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.
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First three letters of patient's last name:

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BITE HISTORY - DETAILS

Location (city, county, state, country)	Date Mosquito Bite (mm/dd/yyyy)

SEXUAL HISTORY

Has the patient had any unprotected (condomless) oral, vaginal, or anal sex in the 6 months prior to Zika diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If No, skip to "Other exposures"
Does the patient have any of the following:	
One or more sex partner(s) who has tested positive for Zika virus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	One or more sex partner(s) with symptoms of Zika virus without another reason for those symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Suspected sexually-acquired Zika infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
If Yes to any of the above, please contact CDPH to complete the supplemental sexual history form.	

OTHER SUSPECTED EXPOSURE

Are any other exposures suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Suspected local acquisition of Zika infection (i.e. no travel to any area with known Zika transmission)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If Yes, specify all locations, details, and dates below.	

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected
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STATE USE ONLY

Case Classification <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information

First three letters of patient's last name:

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CASE DEFINITION

ZIKA (CDPH. definition 2016)

CLINICAL DESCRIPTION

Zika is most often characterized by acute onset of fever with maculopapular rash, arthralgia, or conjunctivitis. Other commonly reported symptoms include myalgia and headache. Clinical illness is usually mild with symptoms lasting for several days to a week. Severe disease requiring hospitalization is uncommon and case fatality is low. However, there have been cases of Guillain-Barré syndrome reported in patients following Zika virus infection. Due to concerns of microcephaly and other poor pregnancy outcomes associated with maternal Zika virus (ZIKV) infection, fetuses and infants of women infected with Zika virus during pregnancy should be evaluated for possible congenital infection and neurologic abnormalities. The majority of people infected with Zika virus are asymptomatic. The incubation period is typically 3–7 days.

LABORATORY CRITERIA FOR DIAGNOSIS

Confirmatory:

- Detection of ZIKV by culture, viral antigen or viral RNA in serum, CSF, tissue, or other specimen (e.g. amniotic fluid, urine, semen, saliva); OR
- Positive ZIKV IgM antibody test of serum or CSF with positive ZIKV neutralizing antibody titers and negative neutralizing antibody titers against dengue or other flaviviruses endemic to the region where exposure occurred.

Presumptive/Probable:

- Positive ZIKV IgM antibody test of serum or CSF with:
 - o Positive neutralizing antibody titers against ZIKV and dengue or other flaviviruses endemic to the region where exposure occurred; OR
 - o Negative dengue virus IgM antibody test and no neutralizing antibody testing performed.

Flavivirus of undetermined species:

- Evidence of recent infection with a flavivirus where the ZIKV IgM is negative and the neutralizing antibody test results on a single specimen are insufficient to determine the identity of the infecting virus.

EPIDEMIOLOGIC LINKAGE

- Resides in or recent travel to an area with known ZIKV transmission , OR
- Sexual contact with a confirmed or probable case within the infection transmission risk window or person with recent travel to an area with known Zika transmission, OR
- Receipt of organs, tissues, blood, or blood products within 30 days of symptom onset, OR
- Association in time and place with a confirmed or probable Zika case, OR
- Likely vector exposure in an area with suitable seasonal and ecological conditions for potential local vectorborne transmission.

CASE CLASSIFICATION

- Confirmed: A clinically compatible case and confirmatory laboratory results, OR a person who does not meet clinical criteria but has an epidemiologic linkage and confirmatory laboratory results.
- Probable: A clinically compatible case and presumptive laboratory results, OR a person who does not meet clinical criteria but has an epidemiologic linkage and presumptive laboratory results.
- Flavivirus infection of undetermined species: A clinically compatible case and evidence of recent infection with a flavivirus where the neutralizing antibody test results on a single specimen are insufficient to determine the identity of the infection virus, OR a person who does not meet clinical criteria but has an epidemiologic linkage and evidence of recent infection with a flavivirus where the neutralizing antibody test results on a single specimen are insufficient to determine the identity of the infection virus.

COMMENT

Rule Out Dengue Testing

The differential diagnosis of Zika virus infection varies based on place of residence, travel history, and exposures. Zika, dengue and chikungunya viruses are transmitted by the same mosquitoes and have similar clinical features. These three viruses can circulate in the same area and can cause occasional co-infections in the same patient. Zika virus is more likely to cause fever with maculopapular rash, arthralgia, or conjunctivitis, chikungunya virus infection is more likely to cause high fever, severe arthralgia, arthritis, rash, and lymphopenia, while dengue virus infection is more likely to cause neutropenia, thrombocytopenia, hemorrhage, shock, and death. It is important to rule out dengue virus infection because proper clinical management of dengue can improve outcome.

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor/actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown