State of California—Health and Human Services Agency

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*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ *Years* ☐ *Months* ☐ *Days*

Address Number & Street - Residence	*Apartment/Unit Number*

City/Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone/Pager*	*Work/School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work/School Location	*Work/School Contact*

Gender
☐ Male ☐ Female ☐ Other: _____

Pregnant? ◉ Yes ○ No ○ Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

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*

Primary Language
◉ English
○ Spanish
○ Other: _____

Ethnicity (check one)
◉ Hispanic/Latino
○ Non-Hispanic/Non-Latino
○ Unk

*Race**
(check all that apply, race descriptions on page 6)
☐ African-American/Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian
- ☐ Other: _____

☐ White
☐ Other: _____
☐ Unk

*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: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ 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	○	○	●	*Highest temperature (specify °F/°C)*	Diarrhea	○	●	○	
Rash	○	●	○	*Description of rash*	Chills	○	●	○	
Conjunctivitis	○	●	○		Cough	○	●	○	
Joint pain	○	●	○	*Joint(s)*	Abdominal pain	○	●	○	
Muscle pain	○	●	○		Fatigue	○	●	○	
Headache	○	●	○		Bloody semen	○	●	○	
Nausea or vomiting	○	●	○		Oral ulcers	○	●	○	
Other symptom (specify)									

Does patient have suspected Guillain-Barre Syndrome or weakness? ☐ **Yes** ☐ **No** ☐ **Unk**
If yes...

Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted		
Weakness	○	●	○	*If yes, is it symmetric?* ☐ Yes ☐ No ☐ Unk	*If yes, is it progressive?* ☐ Yes ☐ No ☐ Unk	*CSF Protein (highest)* _____
Paralysis	○	●	○			*CSF White Blood Cell Count (highest)* _____
Diminished reflexes	○	●	○			*Date of onset of neurologic symptoms: (mm/dd/yyyy)*

Other potential causes of Guillain-Barré syndrome: ☐ Yes ☐ No ☐ Unk (*if yes, please specify below*)
☐ Vaccine_____ ☐ Other febrile illness_____ ☐ Diarrheal illness_____ ☐ Other_____
If yes, date of symptom onset/vaccine: (mm/dd/yyyy)

Is patient a newborn? ☐ **Yes** ☐ **No** ☐ **Unk**
If yes...

Vital Status	☐ Live birth ☐ Fetal loss ☐ Born alive and died ☐ Unk *(If fetal loss, please attach any autopsy results and/or tissue studies)*

Signs / Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Microcephaly	○	●	○		*Gestational age at birth_____weeks* *Dating by:* ☐ Obstetrical estimate ☐ Last menstrual period ☐ Ultrasound ☐ Newborn examination
Intracranial calcifications	○	●	○		*Head circumference at birth_____cm_____percentile*
Newborn hearing screen abnormal	○	●	○		*Length at birth_____cm_____percentile*
Newborn eye exam abnormal	○	●	○		*Birthweight_____grams_____percentile*

Brain imaging results:

Eye examination findings:

Maternal history: Did mother experience symptoms of Zika during pregnancy? ☐ Yes ☐ No ☐ Unk
Was mother tested for Zika virus? ☐ Yes ☐ No ☐ Unk (*If yes, include test results in notes section below*)
If yes, did mother test positive for Zika virus? ☐ Yes ☐ No ☐ Unk

Continued on page 3

First three letters of patient's last name: | | | |

If patient is PREGNANT:	
Has a fetal ultrasound been performed? ☐ Yes ☐ No ☐ Unk *(If Yes, please attach all ultrasound reports)*	*If yes, fetal ultrasound results:* ☐ Normal ☐ Microcephaly ☐ Intracranial calcifications ☐ Other findings: _____ *If yes, dates of ultrasounds (mm/dd/yy)* _____ *Gestational age at ultrasound* _____ *weeks*

PAST MEDICAL HISTORY	
Has the patient been previously diagnosed with dengue? ☐ Yes ☐ No ☐ Unk	*If yes, date of diagnosis (mm/dd/yyyy)*
Has the patient been vaccinated for yellow fever? ☐ Yes ☐ No ☐ Unk	*Has the patient been vaccinated for Japanese encephalitis virus?* ☐ Yes ☐ No ☐ Unk

Has the patient had a pregnancy complicated by suspected Zika infection? ☐ Yes ☐ No ☐ Unk (*Check all that apply*)
☐ Fetal loss ☐ Perinatal death ☐ Live birth ☐ Microcephaly ☐ Intracranial calcifications ☐ Positive test for Zika infection
☐ Other_____ (*Please attach related results including MRI/CT scan, autopsy results*)

HOSPITALIZATION		
Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unk	*Was patient hospitalized?* ☐ Yes ☐ No ☐ Unk	*If Yes, how many total hospital nights?*

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		
Outcome? ☐ Survived ☐ Died ☐ Unk	*If Survived,* Survived as of_____ *(mm/dd/yyyy)*	*Date of Death (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

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	*Type of Test*		
◉ Serum ○ Urine ○ CSF ○ Umbilical cord blood ○ Amniotic fluid ○ Other:_____	◉ PCR ○ ELISA-IgM ○ IFA-IgM ○ NAT (blood bank) ○ PRNT ○ Other (specify):_____		
	Interpretation ○ Positive ○ Negative ◉ Equivocal ○ Indeterminate	*Results*	*Collection Date (mm/dd/yyyy)*
	Laboratory Name		*Telephone Number*

Specimen Type 2	*Type of Test*		
◉ Serum ○ Urine ○ CSF ○ Umbilical cord blood ○ Amniotic fluid ○ Other:_____	◉ PCR ○ ELISA-IgM ○ IFA-IgM ○ NAT (blood bank) ○ PRNT ○ Other (specify):_____		
	Interpretation ◉ Positive ○ Negative ○ Equivocal ○ Indeterminate	*Results*	*Collection Date (mm/dd/yyyy)*
	Laboratory Name		*Telephone Number*

Please list additional test results under Notes.

LABORATORY RESULTS SUMMARY - OTHER

Hematology ◉ Yes ○ No ○ Unk	*Date Collected (mm/dd/yyyy)*	*WBC*	*HCT*	*Hb*	*Platelets*

Other laboratory diagnostics performed (e.g., IHC, virus isolation)? ◉ Yes ○ No ○ Unk	*If Yes, describe*

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? ☐ Yes ☐ No ☐ Unk *Date:*_____	*Did patient donate an organ during the incubation period?* ☐ Yes ☐ No ☐ Unk *Date:*_____
Did patient receive a blood transfusion during the incubation period? ☐ Yes ☐ No ☐ Unk *Date:*_____	*Did patient receive an organ transplant during the incubation period?* ☐ Yes ☐ No ☐ Unk *Date:*_____

TRAVEL HISTORY

*Did patient travel **outside of county of residence** during the incubation period?* ☐ Yes ☐ No ☐ Unk	*Has the patient traveled* outside of California *during the incubation period?* ☐ Yes ☐ No ☐ Unk
Has the patient traveled outside the U.S. during the incubation period? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Unk	*If Yes, specify all locations and dates below.*

First three letters of patient's last name: | | | |

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? ☐ Yes ☐ No ■ 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? ☐ Yes ☐ No ☐ Unk	*One or more sex partner(s) with symptoms of Zika virus without another reason for those symptoms?* ☐ Yes ☐ No ☐ Unk

Suspected sexually-acquired Zika infection?
☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Unk	*Suspected local acquisition of Zika infection (i.e. no travel to any area with known Zika transmission)?* ☐ Yes ☐ No ☐ 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
☐ Clinician ☐ Laboratory ☐ Other (specify): _____

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐ Confirmed ☐ Probable ☐ Suspected

STATE USE ONLY

Case Classification
☐ Confirmed ☐ Probable ☐ Suspected ☐ Not a case ☐ Need additional information

First three letters of patient's last name: | | | |

CASE DEFINITION

ZIKA (CDPH, working 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:
  - Positive neutralizing antibody titers against ZIKV and dengue or other flaviviruses endemic to the region where exposure occurred; OR
  - 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

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- 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
- 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