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| **Case Information (Use identifiers applicable to your systems)**  State/Local ID:\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­ State lab number:\_\_\_\_\_\_\_\_\_\_\_\_\_  CDC R-number:\_\_\_\_\_\_\_\_\_\_\_\_ ArboNET ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIKV ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| State:\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date form completed:\_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (MM/DD/YYYY) | | | |
| **Interviewer Information**  Interviewer name (First, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State/local health department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary phone number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary phone number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Patient Demographics and Contact Information** | | | |
| Patient last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient first name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (MM/DD/YYYY) | Sex: 🞏 Male 🞏 Female | | Pregnant: 🞏 Yes 🞏 No 🞏 N/A |
| State of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Phone number: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Clinical Information** | | | |
| Date of symptom onset \_\_\_\_/\_\_\_\_/\_\_\_\_\_ OR 🞏 Person was asymptomatic  Fever 🞏 Yes 🞏 No  Rash 🞏 Yes 🞏 No If yes: Type: 🞏 Maculopapular 🞏 Petechial 🞏 Purpuric 🞏 Other  Pruritic: 🞏 Yes 🞏 No Distribution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Arthralgia 🞏 Yes 🞏 No  Conjunctivitis 🞏 Yes 🞏 No  Other symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospitalized 🞏 Yes 🞏 No If yes, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates/Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Exposure Information before Symptom Onset (or specimen collection if asymptomatic)** | | | |
| 1. Did the patient travel to or live outside his/her city or county in the 14 days before symptom onset or specimen collection (if asymptomatic)\*?   🞏 Yes 🞏 No | | | |
| If yes: Location(s) of travel (country, state, city, county, and/or territory):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Travel start date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Return date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Travel start date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Return date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Travel start date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Return date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  *(Follow health department protocol to evaluate for possible travel-associated Zika virus infection; see* [*https://wwwnc.cdc.gov/travel/page/zika-travel-information*](https://wwwnc.cdc.gov/travel/page/zika-travel-information) *for areas with risk of Zika virus)*  *\* Recent Zika virus infection is most reliably determined by a positive nucleic acid test (NAT). Because NAT may be positive for longer than 14 days after infection in some cases, and because IgM is generally detected for at least 3 months after infection, if travel to an area with risk of Zika occurred earlier than 14 days before specimen collection, jurisdictions may consider further evaluation for travel-associated exposures.  Please contact CDC for further assistance.* | | | |
| 1. Did the patient have sex (vaginal, oral, anal or sharing of sex toys, without a condom) with any person who returned from travel to a country or US state or territory with risk of Zika virus in the previous 6 months (if partner was male) or 2 months (if partner was female) or who had confirmed Zika virus infection?   If yes:  Name of contact (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of contact (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞏 Yes 🞏 No  Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| *(If sexual transmission of Zika virus is suspected, please contact CDC’s Arboviral Diseases Branch at* [ZIKA\_ADB\_EPI@cdc.gov](mailto:ZIKA_ADB_EPI@cdc.gov) *for sexual transmission case follow up and form)* | | | |
| 1. Did the patient receive a blood transfusion or organ or tissue transplant during the 28 days before symptom onset or specimen collection (if asymptomatic)? | | 🞏 Yes 🞏 No | |
| If yes:  Date of transfusion/transplant (1) \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Type of product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of transfusion/transplant (2) \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Type of product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    *(CDC Blood Safety Investigation Toolkit may be used to collect detailed information for potential transfusion-associated infections:* [*http://www.cdc.gov/bloodsafety/tools/investigation-toolkit.html*](http://www.cdc.gov/bloodsafety/tools/investigation-toolkit.html)*)* | | | |
| 1. Did the patient work in a laboratory that collects, processes, or tests blood or body fluids or in a research laboratory working on Zika virus in the 14 days before symptom onset or specimen collection (if asymptomatic)? 🞏 Yes 🞏 No   If yes: Laboratory name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Follow health department protocol to evaluate for possible occupational exposure)* | | | |
| 1. Did the patient share needles with another person? 🞏 Yes 🞏 No   If yes:  *(Follow health department protocol to evaluate for possible blood-borne transmission)* | | | |
| 1. If no travel-associated or other known exposures (e.g., sexual, transfusion/transplant, blood/body fluid) to Zika virus identified, investigate for possible local, mosquito-borne transmission.   (*Possible Local Mosquito-Borne Transmission Zika Virus Case Investigation Form may be used to investigate potential areas of exposure:* [*https://www.cdc.gov/zika/public-health-partners/transmission-investigation-form.docx*](https://www.cdc.gov/zika/public-health-partners/transmission-investigation-form.docx)) | | | |