Zika Virus Report Form

Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308

(Report by completing and faxing this form to 860-509-7910. For questions, call 860-509-7994.)

Patient Name (Last) (First) (MI)	Parent or Guardian Name	Age	Birth Date	Patient's Telephone Home Work Cell

Address (No. and Street) (Apt. #) (City or Town)

(State) (Zip Code)

(Primary Language Spoken)
☐ English ☐ Spanish ☐ Other: specify:_____

Gender ☐ Male ☐ Female ☐ Other specify: ☐ Unknown

Race ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ Other specify: ☐ Unknown

Hispanic/Latino ☐ Yes ☐ No ☐ Unknown

Is patient pregnant? ☐ Yes ☐ No ☐ Unknown
# of weeks: _____Ultrasound findings: _____

Did patient have recent travel to a Zika virus affected area? ☐ Yes ☐ No ☐ Unknown

If yes, country or countries visited:_____

Date of arrival: _____ Date of departure: _____

Vaccination History - *Check all that apply*

☐ Yellow fever
☐ Japanese encephalitis virus

Reporting healthcare provider name and address:

Direct telephone

_____

If hospitalized, **hospital**:	Date Admitted	Date Discharged
Name City State	Patient ID #	

Name of person completing report: _____

Address:_____

Phone: _____ FAX: _____ Report Date: _____

SYMPTOMS

Did patient have symptoms? ☐ Yes ☐ No ☐ Unknown
if yes, check all that apply:

Primary Symptoms **Symptom onset date**: _____

Fever	☐ Yes	☐ No	☐ Unknown
If yes, temp: _____ temp date of onset: _____			
Rash (maculopapular)	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown
Arthralgia	☐ Yes	☐ No	☐ Unknown

Secondary Symptoms

Fatigue	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Orbital pain	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown
Vomiting	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown

Was patient diagnosed with Guillain–Barré syndrome?
☐ Yes ☐ No ☐ Unknown

FOR DPH STAFF USE ONLY

Case = 2 of 4 Primary Symptoms within 2 weeks of travel to a Zika virus affected area.

Approved for Zika testing: ☐ Yes ☐ No **By**: _____ (Initials)

Test type approved: ☐ RT-PCR ☐ IgM ELISA

Date provider notified: _____

Name of person notified: _____ **By**: _____ (Initials)