Tennessee Department of Health

Zika Virus Disease Form

Please fill out this form as completely as possible and send or fax to Central Office: Tennessee Department of Health, Vector Borne Disease Program
630 Hart Lane, Nashville, TN 37216 Phone: 615.262.6356 Fax:615.262.6324

Revised: 04/2018

Demographics

CASE ID#:_____

***Last Name:** _____ ***First:** _____ **Middle:** _____ ***DOB:** ____/____/_____

Reported Age: _____ □ Days □ Months □ Years ***Sex:** □ Male □ Female □ Unknown

***Pregnancy Status:** □ Yes □ No □ Unknown If yes, estimated due date: _____

Any abnormal neurologic findings noted on ultrasound? □ Yes □ No □ Don't know/Not performed

***Street Address:** _____

***City:** _____ ***County:** _____ ***State:** _____ ***Zip:** _____

Phone - Home: _____ **Work:** _____ **Cell:** _____

***Ethnicity:** □ Hispanic/Latino □ Non-Hispanic/Non-Latino ***Race:** □ American Indian/Alaskan □ Asian □ Black/African American □ Hawaiian/Pacific Islander □ White □ Other

If infant patient:

Mother's Name: _____

Mother's Zika Test Result: □ Positive □ Inconclusive □ Negative □ Unknown

Mother's Test Date: _____/_____/_____ □ Unknown/Not done

Clinical Information

HOSPITAL/PROVIDER

Physician/Provider: _____

Physician/Provider Phone Number: _____

***Was the patient hospitalized for this illness?** □ Yes □ No □ Unknown

If yes, **Hospital:** _____

Admission:____/____/____ Discharge: ____/___/____

***Did the patient die from this illness?**

□ Yes (Date of death ____/____/____) □ No □ Unknown

Immunization Status:

Has this person every received vaccination for: Yellow Fever □ Yes □ No □ Unknown

Japanese Encephalitis □ Yes □ No □ Unknown

SIGNS/SYMPTOMS

***Illness Onset Date: ___/___/____** **Illness End Date:** ____/____/____

□ Asymptomatic
□ Fever Max temp. _____
□ Rash
□ Conjunctivitis
□ Joint pain
□ Chills
□ Fatigue
□ Cough
□ Headache
□ Muscle pain
□ Nausea or vomiting
□ Diarrhea
□ Abdominal pain
□ Other (please describe) _____

Laboratory

ORDER INFO

***Reporting Facility:** _____ City/ State: _____

Ordering Facility: _____ City/ State: _____

Ordering Provider: _____ City/ State: _____

Lab Report Date: ___/___/____ ***Date Received by Public Health: ___/____/_____** Ordered Test:_____

Specimen Source:_____ Accession Number:_____ Patient Status: □ Hospitalized □ Outpatient □ Unk.

TEST RESULT (S)

Resulted Test	Coded Result 1	Numeric Result 1	Date Collected 1	Coded Result 2	Numeric Result 2	Date Collected 2
PCR (serum)	□ Pos □ Neg			□ Pos □ Neg		
PCR (urine)	□ Pos □ Neg			□ Pos □ Neg		
EIA/ELISA IgM	□ Pos □ Neg			□ Pos □ Neg		
EIA/ELISA IgM (CSF)	□ Pos □ Neg			□ Pos □ Neg		
PRNT	□ Pos □ Neg			□ Pos □ Neg		

Exposure History

TRAVEL HISTORY

Did the patient travel outside home county in the 4 weeks before symptom onset? □ Yes □ No

If yes, where? _____
(Country/State/City)

Dates of travel: ____/_____/_____ to ____/_____/_____

Was the patient part of a group trip?

□ Yes (What group:_____) □ No

Group Coordinator (Name/phone:_____)

Any known ill contacts? (Name/phone:_____)

OTHER

Sources of Infection (select all that apply - Y=Yes, N=No, U=Unknown):
^In the last 30 days since symptom onset

Y N U
□ □ □ Occupationally lab acquired
□ □ □ Non-ocupationally lab acquired
□ □ □ **^Blood donor** Donation date: ___/____/____
□ □ □ **^Identified by blood donor screening?**
□ □ □ **^Organ donor** Donation date: ___/____/___
□ □ □ **^Blood transfusion received** Date: ___/____/____
□ □ □ **^Organ transplant received** Date: ___/____/____
□ □ □ Infected in Utero
□ □ □ Breastfed Infant

Investigation Summary

***Jurisdiction**_____

Investigator:_____

***Investigation Status:** □ **Open** □ **Closed**

Investigation Start Date: _____/_____/_____

Case Status: □ Confirmed □ Probable □ Not a Case

Provided Education regarding □ Mosquito Avoidance □ Sexual Transmission