**ZIKA VIRUS CASE REPORT FORM**

*Please complete for confirmed cases only and forward by fax to (204) 948-3044*

***CASE INFORMATION***

Given Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHIN (9digits) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate (YYYY/MM/DD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M/F/Unknown RHA \_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient been advised that general (non-identifiable) information regarding their case may be reported in a public announcement? Yes/No/Unknown

***CLINICAL DETAILS***

Asymptomatic **OR** Date of symptom onset (YYYY/MM/DD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms (check all that apply):

Rash Elevated temperature Arthralgia Myalgia

Headache Non-purulent conjunctivitis Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was case hospitalized? Yes/No/Unknown Name/location of hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of hospitalization (YYYY/MM/DD) From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severe outcome: Yes/No/Unknown If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant? Yes/No/Unknown If yes, weeks of gestation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, date of last menstrual period (YYYY/MM/DD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, outcome of pregnancy:

Healthy birth

Congenital Anomaly (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fetal death/still birth

Spontaneous Abortion

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***EXPOSURE DETAILS***

*Exposure period starts 12 days prior to symptom onset*

*Viraemic period is symptom onset date plus 7 days*

Travel history during exposure and viraemic periods: Yes/No/Unknown

If yes:

|  |  |  |
| --- | --- | --- |
| Place (Country/City) | Dates (from –to) | Presence of mosquitoes noted (Y/N) |
|  |  |  |
|  |  |  |
|  |  |  |

Likely place of acquisition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no travel history (locally acquired):

Did case have sexual contact during exposure period with an individual who traveled to a Zika infected area within the 8 weeks? Yes/No/Unknown

Did case receive a blood transfusion within the last 12 days? Yes/No/Unknown

|  |
| --- |
| Additional details: |

***LABORATORY:***

Date of specimen collection (YYYY/MM/DD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date case reported to MHHLS (YYYY/MM/DD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laboratory test (check all that apply):

RT-PCR IgM ELISA PRNT

|  |
| --- |
| Additional comments: |

***REPORTING INFORMATION:***

Form completed by (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization/Health Unit/Regional Health Authority

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_