



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
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Address (No. and Street)	(Apt. #)	(City or Town)
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(State)	(Zip Code)	(Primary Language Spoken) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: specify: _____
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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: Name City State	Date Admitted	Date Discharged
	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)

Specimen Type: Serum Urine

Test type approved: RT-PCR IgM ELISA

Date provider notified: _____

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