Congenital Zika Virus Form

Department of Public Health
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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.)

Infant Information

Name (Last) (First) (MI) | **Birth Date** | **Gestation Age**

Ultrasound

Date 1: _____ Date 2: _____

Microcephaly ☐ Yes ☐ No Microcephaly ☐ Yes ☐ No

If yes, percentile: _____ If yes, percentile: _____

Intracranial calcifications ☐ Yes ☐ No Intracranial calcifications ☐ Yes ☐ No

Other:_____ Other:_____

Examination

Was an ophthalmologic exam performed? ☐ Yes ☐ No

If yes, result: _____

Was a hearing test performed? ☐ Yes ☐ No

If yes, result: _____

Clinical Findings Postnatal

Microcephaly ☐ Yes Length: _____

Intracranial calcifications ☐ Yes Weight: _____

Other findings: _____ Head circumference: _____

_____ Other testing: _____

Samples available for testing

☐ Cord blood
☐ Placenta fixed ☐ frozen ☐
☐ Serum
☐ Other: _____

Pediatrician: Name: _____ Phone: _____

Patient/Mother Information

Name (Last) (First) (MI) Parent or Guardian Name | **Age** | **Birth Date** | **Patient's Phone**

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

Primary Language Spoken

☐ English ☐ Spanish ☐ Other: _____

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

Hispanic/Latino
☐ Yes
☐ No
☐ Unknown

Is patient **pregnant**?
☐ Yes ☐ No ☐ Unknown

If yes, # of weeks: _____

Did mother **travel** to a Zika virus affected area during pregnancy?
☐ Yes ☐ No ☐ Unknown
If yes, country or countries visited: _____

Arrival date: _____ Departure date: _____

Did patient have **sexual contact** (with partner with travel history) during pregnancy?
☐ Yes ☐ No ☐ Unknown

Vaccination History (check all that apply)
☐ Yellow fever ☐ Japanese encephalitis virus

Obstetrician/Provider
Name: _____ Phone: _____

Symptoms: Did mother have symptoms? ☐ Yes ☐ No If yes, onset date: _____

Fever: ☐ Yes ☐ No ☐ Unknown If yes, highest temp: _____ Onset date of temp: _____

Rash (maculopapular) ☐ Yes ☐ No ☐ Unknown **C**onjunctivitis: ☐ Yes ☐ No ☐ Unknown **A**rthralgia: ☐ Yes ☐ No ☐ Unknown

Tested: Was mother tested for Zika virus? ☐ Yes ☐ No if yes, ☐ IgM result: _____ ☐ PCR result: _____

Reporters Information

Reporting healthcare provider name and address

Direct phone: _____

Hospital Information:
Name:
City:
State:

Date **Admitted** | Date **Discharged**

Patient ID #:

Name of person completing the form: _____ Address: _____

Phone: _____ FAX: _____ Report Date: _____

FOR DPH STAFF USE ONLY **Case = 2 of 4 symptoms within 2 weeks of travel to a Zika virus affected area.**

DPH approval: ☐ Yes ☐ No approval by: _____ (full name) CDC approval: ☐ Yes ☐ No approval by: _____ (full name)

Date provider notified: _____ Name of person notified: _____ By: _____ (initials)

Date tested: _____ MAVEN ID: _____