Form Approved

OMB Control No.: 0920-XXXX Expiration date: XX/XX/XXXX

Today's date:			1	
	MM	DD	YYYY	

ZIKV RNA Persistence (ZIRP): Pregnant Woman Screening Form

Clinic Information	Patient Information		
Clinic name:	Last name:		
Municipality*:	First name:		
Study site # (if applicable):	Date of Birth (mm/dd/yyyy):	 : 	
1. Inclusion Criteria			
Is the patient RT-PCR positive* for ZIKV on blood of	or urine?	□₁Yes	□₀ No
Is the patient 15 years of age or older?		□₁Yes	\square_0 No
Does the patient speak English or Spanish?		□₁Yes	\square_0 No
Is the patient able to return every 2 weeks for spec	imen collection?	□₁Yes	\square_0 No
Is the patient willing to consider enrolling their infar	nt into the study at birth?	□₁Yes	$\square_{\!\scriptscriptstyle 0}$ No
If any of the above inclusion criteria is answer	red "no" the patient is NOT eligibl	e for study	
2. Exclusion Criteria			
Is the patient not physically or psychologically able clinical judgment?	to participate based on	□₁Yes	□₀ No
Is the patient's pregnancy ectopic or molar?		□₁Yes	$\square_{\!\scriptscriptstyle 0}$ No
If 1 or more of the above exclusion criteria is answ	wered "yes" the patient is NOT eli	gible for st	udy
3. Eligibility Determination			
The patient is eligible for the study. (All answers to in to exclusion criteria are No.)	nclusion criteria questions are	Yes AND	all answers
	□₁Yes □₀ No		
		Page Version No	

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Form Approved OMB Control No. Expiration date: 3	
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4. Informed C	Consent
	t sign informed consent for participation? $\square_1 Yes \square_0 No$
4.1 If yes,	4.1a Date when informed consent was signed (mm/dd/yyyy):
	4.1b Was the patient given a copy of the consent? $\square_1 Yes \square_0 No$
4.2 If no,	4.2a. Why not?
5. Enrollment	t
5.1 Was the p	patient enrolled? \square_1 Yes \square_0 No
5.2 Patient id	entifier number:

Page 2 of 2 Version No. 12.0