Form Approved
OMB Control No. 0920-XXXX
Exp. date: XX/XX/XXXX

Attachment 3: Zika Virus Disease Enhanced Surveillance – Neurologic symptoms associated with Zika virus disease

Demographic Information

Case ID (ArboNET):_____ Control for Case ID:_____

State of residence:_____ County of residence:_____

Age: _____ ☐ Years ☐ Months ☐ Days Sex: ☐ Male ☐ Female

Pregnant: ☐ Yes ☐ No ☐ Unknown Est Date Delivery: ____/____/____ OR Last Menstrual Period: ____/____/____

Race (*Select all appropriate):* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Imported From: ☐ Not Imported ☐ Acquired Out of State ☐ Acquired Out of Country ☐ Unknown

Country of Origin:_____ Travel dates:_____

State of Origin:_____ Travel dates: _____

Other possible exposures: ☐ Sexual ☐ Breastfeeding ☐ Blood products ☐ Organs

Past Medical History

Hypertension	☐ Yes ☐ No ☐ Unk
Heart disease	☐ Yes ☐ No ☐ Unk
Diabetes mellitus	☐ Yes ☐ No ☐ Unk
Asthma/respiratory disease	☐ Yes ☐ No ☐ Unk Specify:_____
COPD	☐ Yes ☐ No ☐ Unk
Autoimmune disorder	☐ Yes ☐ No ☐ Unk
Cancer	☐ Yes ☐ No ☐ Unk
Other immune deficiency	☐ Yes ☐ No ☐ Unk
Liver/hepatic disease	☐ Yes ☐ No ☐ Unk
Kidney/renal disease	☐ Yes ☐ No ☐ Unk
Thyroid disease	☐ Yes ☐ No ☐ Unk
Seizure disorder	☐ Yes ☐ No ☐ Unk
Other neurologic disease	☐ Yes ☐ No ☐ Unk Specify:_____
Tobacco use	☐ Yes ☐ No ☐ Unk If yes: ☐ Current ☐ Past
Alcoholism	☐ Yes ☐ No ☐ Unk
Intravenous drug use	☐ Yes ☐ No ☐ Unk If yes: ☐ Current ☐ Past
Other medically important condition	☐ Yes ☐ No ☐ Unk Specify:_____

Pre-existing Medications and Treatments

Medications to treat hypertension	☐ Yes ☐ No ☐ Unk
Medications to treat coronary heart disease	☐ Yes ☐ No ☐ Unk
Medications to treat congestive heart failure	☐ Yes ☐ No ☐ Unk
Chemotherapy	☐ Yes ☐ No ☐ Unk
Other treatments for cancer	☐ Yes ☐ No ☐ Unk
Medications that suppress the immune system	☐ Yes ☐ No ☐ Unk
Insulin or other meds to treat diabetes	☐ Yes ☐ No ☐ Unk
Hemodialysis	☐ Yes ☐ No ☐ Unk
Other treatments for kidney disease	☐ Yes ☐ No ☐ Unk
Oral or injected steroids	☐ Yes ☐ No ☐ Unk

Clinical Information

Illness onset date: _____/_____/_____

Clinical syndrome: ☐ Febrile illness ☐ Encephalitis/meningoencephalitis ☐ Meningitis ☐ Acute flaccid paralysis ☐ Guillain-Barré syndrome ☐ Other neuroinvasive presentation ☐ Other clinical

Case Status (ArboNET): ☐ Confirmed ☐ Probable

Fever	☐ Yes ☐ No ☐ Unk ☐ Subjective ☐ Measured (Max temperature: _____)
Chills/Rigors	☐ Yes ☐ No ☐ Unk
Rash	☐ Yes ☐ No ☐ Unk Type: ☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ Other:_____ Pruritic: ☐ Yes ☐ No ☐ Unk Distribution:_____
Headache	☐ Yes ☐ No ☐ Unk
Retro-orbital pain	☐ Yes ☐ No ☐ Unk
Conjunctivitis	☐ Yes ☐ No ☐ Unk
Oral ulcers	☐ Yes ☐ No ☐ Unk
Nausea/Vomiting	☐ Yes ☐ No ☐ Unk
Diarrhea	☐ Yes ☐ No ☐ Unk
Arthralgia	☐ Yes ☐ No ☐ Unk
Arthritis	☐ Yes ☐ No ☐ Unk
Myalgia	☐ Yes ☐ No ☐ Unk
Sore throat	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐ Unk
Lymphadenopathy	☐ Yes ☐ No ☐ Unk
Abdominal pain	☐ Yes ☐ No ☐ Unk
Edema	☐ Yes ☐ No ☐ Unk Specify:_____
Other	☐ Yes ☐ No ☐ Unk Specify:_____

Neurologic Symptoms

Neurologic symptom onset date:_____/_____/_____ First neurologic symptom:_____	
In 2 months preceding neurologic symptoms	☐ Gastrointestinal illness ☐ Upper respiratory illness ☐ Vaccinations If yes, list:_____
Paresis/Paralysis	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Location (affected limbs):_____ Progression:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Stiff Neck	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Photophobia	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Neurologic Symptoms (continued)	
Ataxia	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Altered mental status	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Seizures	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Paresthesia	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Location (affected limbs):_____ Progression:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Acute bilateral, progressive weakness	☐ Yes ☐ No ☐ Unk

	If yes (all that apply): ☐ Extremities ☐ Facial ☐ Extraocular muscles Weakness starting in lower extremities and then ascending: ☐ Yes ☐ No ☐ Unk Maximal weakness/clinical nadir 12h–28d from neurologic onset: ☐ Yes ☐ No ☐ Unk Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Impaired coordination	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Frequent stumbling or unsteady gait	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Problems with balance	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Uncontrolled or repetitive eye movements	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Trouble performing fine motor tasks	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Neurologic Symptoms (continued)	
Slurred speech or other vocal changes	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Behavioral or personality changes	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Dizziness	☐ Yes ☐ No ☐ Unk If yes: ☐ Patient reported ☐ Documented by healthcare provider Onset: _____/_____/_____ Duration:_____ Resolution: ☐ Complete improvement ☐ Partial improvement ☐ No improvement ☐ Unknown
Reduced/absent deep tendon reflexes	☐ Yes ☐ No ☐ Unk

Autonomic instability	☐ Yes ☐ No ☐ Unk	
Neuropathic pain	☐ Yes ☐ No ☐ Unk If yes, describe: _____	
Alternative condition or possible diagnosis	☐ Yes ☐ No ☐ Unk	
Neurologist diagnosis:_____		
Other:		
Outcomes		
Emergency department	☐ Yes ☐ No ☐ Unk	
Hospitalized	☐ Yes ☐ No ☐ Unk	Admission: ____/____/____ Discharge:____/____/____ Days hospitalized:_____ Multiple admissions: ☐ Yes ☐ No ☐ Unk Number:_____
ICU	☐ Yes ☐ No ☐ Unk	Admission: ____/____/____ Discharge:____/____/____ Days in intensive care:_____ Intubation: ☐ Yes ☐ No ☐ Unk
Admission diagnoses	Primary diagnosis or ICD 10:_____ Additional diagnoses:_____	
Discharge diagnoses	Primary diagnosis or ICD 10:_____ Additional diagnoses:_____	
Died	☐ Yes ☐ No ☐ Unk	Date of Death:_____/_____/_____ Causes of death: 1._____ 2._____ 3._____
Discharged to rehab	☐ Yes ☐ No ☐ Unk	

Treatments Administered During Hospitalization		
Antimicrobials	☐ Yes ☐ No ☐ Unk	Specify:_____
Steroids/other immune modulating	☐ Yes ☐ No ☐ Unk	Specify:_____
Blood products	☐ Yes ☐ No ☐ Unk	Specify:_____
IVIG	☐ Yes ☐ No ☐ Unk	Dates:_____

Zika Virus Test Results	**Dengue Virus Test Results**
Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial	Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC ☐ NS1 Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial
Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine	Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine

Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial	Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC ☐ NS1 Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial
Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial	Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC ☐ NS1 Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial
Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial	Specimen collected: _____/_____/_____ Specimen Type: ☐ Serum ☐ CSF ☐ Urine Test: ☐ IgM ☐ PRNT ☐ PCR/NAT ☐ IHC ☐ NS1 Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial

Laboratory Tests

CBC performed ☐ Yes ☐ No ☐ Unk Leukopenia *(<4,500)* ☐ Yes ☐ No ☐ Unk Nadir:_____ ; Date:____/___/____ Thrombocytopenia *(<150,000)* ☐ Yes ☐ No ☐ Unk Nadir:_____ ; Date:____/___/____ Leukocytosis *(>11,000)* ☐ Yes ☐ No ☐ Unk Max:_____ ; Date:____/___/____				
Abnormal liver enzymes	AST: ☐ Yes ☐ No ☐ Unk Max:_____; Date:____/____/____ ALT: ☐ Yes ☐ No ☐ Unk Max:_____; Date:____/____/____			
LP performed	☐ Yes ☐ No ☐ Unk	Date:___/____/____ WBC:_____ RBC:_____ Protein:_____ Glucose:_____	Date:___/____/____ WBC:_____ RBC:_____ Protein:_____ Glucose:_____	Date:___/____/____ WBC:_____ RBC:_____ Protein:_____ Glucose:_____
MRI	☐ Yes ☐ No ☐ Unk	Date:___/____/____	Abnormal results: ☐ Yes ☐ No ☐ Unk If yes, describe:_____ _____	
CT	☐ Yes ☐ No ☐ Unk	Date:___/____/____	Abnormal results: ☐ Yes ☐ No ☐ Unk If yes, describe:_____ _____	
EMG/NCS	☐ Yes ☐ No ☐ Unk	Date:___/____/____	Abnormal results: ☐ Yes ☐ No ☐ Unk If yes, describe:_____ _____ Consistent with GBS: ☐ Yes ☐ No ☐ Unk If yes: ☐ Axonal (i.e., AMAN or AMSAN) ☐ Mixed axonal and demyelinating ☐ Demyelinating (i.e., AIDP) ☐ Unknown subtype	

Other test	☐ Yes ☐ No ☐ Unk	Date:___/_____/_____	Abnormal results: ☐ Yes ☐ No ☐ Unk If yes, describe:_____ _____