

Attachment 4: Zika Virus Disease Enhanced Surveillance – Postnatally acquired Zika virus disease among children aged <18 years

Demographic Information	
Case ID (ArboNET): _____ Control for Case ID: _____	
State of residence: _____ County of residence: _____	
Age: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Est Date Delivery: ____/____/____ OR Last Menstrual Period: ____/____/____	
Race (Select all appropriate): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Co-morbidities: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Describe: _____	
Imported From: <input type="checkbox"/> Not Imported <input type="checkbox"/> Acquired Out of State <input type="checkbox"/> Acquired Out of Country <input type="checkbox"/> Unknown	
Country of Origin: _____ Travel dates: _____	
State of Origin: _____ Travel dates: _____	
Other possible exposures: <input type="checkbox"/> Sexual <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Blood products <input type="checkbox"/> Organs	
Clinical Information	
Illness onset date: ____/____/____	
Clinical syndrome: <input type="checkbox"/> Febrile illness <input type="checkbox"/> Encephalitis/meningoencephalitis <input type="checkbox"/> Meningitis <input type="checkbox"/> Acute flaccid paralysis <input type="checkbox"/> Guillain-Barré syndrome <input type="checkbox"/> Other neuroinvasive presentation <input type="checkbox"/> Other clinical _____	
Case Status (ArboNET): <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Subjective <input type="checkbox"/> Measured (Max temperature: _____)
Chills/Rigors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Type: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Other: _____ Pruritic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Distribution: _____
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Retro-orbital pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Oral ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Public reporting burden of this collection of information is estimated to average XX minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

Arthralgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Paresis/Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Stiff Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Ataxia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Altered mental status	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Clinical Information (continued)		
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Lymphadenopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Paresthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Specify: _____
CBC performed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Leukopenia <input type="checkbox"/> Yes (<4,500) Nadir: _____ <input type="checkbox"/> No <input type="checkbox"/> Unk Thrombocytopenia <input type="checkbox"/> Yes (<150,000) Nadir: _____ <input type="checkbox"/> No <input type="checkbox"/> Unk
LP performed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	CSF Pleocytosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk (WBC count >=5)
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Specify: _____
Outcomes		
Emergency department	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Hospitalized	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Admission Date: ____/____/____ Discharge Date: ____/____/____ OR Days hospitalized: _____
Died	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date of Death: ____/____/____
Zika Virus Test Results		Dengue Virus Test Results
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial		Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial
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