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

Attachment 5: Zika Virus Disease Enhanced Surveillance – Hospitalization 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

Public reporting burden of this collection of information is estimated to average 120 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

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
Paresis/Paralysis	☐ Yes ☐ No ☐ Unk
Stiff Neck	☐ Yes ☐ No ☐ Unk
Ataxia	☐ Yes ☐ No ☐ Unk
Altered mental status	☐ Yes ☐ No ☐ Unk
Seizures	☐ Yes ☐ No ☐ Unk
Sore throat	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐ Unk
Lymphadenopathy	☐ Yes ☐ No ☐ Unk

Paresthesia	☐ Yes ☐ No ☐ Unk
Abdominal pain	☐ Yes ☐ No ☐ Unk
Edema	☐ Yes ☐ No ☐ Unk Specify:_______________
Other	☐ Yes ☐ No ☐ Unk Specify:_______________

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:_______________	

Outcomes (continued)

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:_______________

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

Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial	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 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 Result: ☐ Positive ☐ Negative ☐ Equivocal Performing Lab: ☐ CDC ☐ State PH ☐ Commercial
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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:___________________________ ____
Other test	☐ Yes ☐ No ☐ Unk	Date:___/____/____	Abnormal results: ☐ Yes ☐ No ☐ Unk If yes, describe:___________________________ ____