Today’s date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

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 or urine? | □1Yes □0 No |
| Is the patient 15 years of age or older? | □1Yes □0 No |
| Does the patient speak English or Spanish? | □1Yes □0 No |
| Is the patient able to return every 2 weeks for specimen collection? | □1Yes □0 No |
| Is the patient willing to consider enrolling their infant into the study at birth? | □1Yes □0 No |

**If any of the above inclusion criteria is answered “no” the patient is NOT eligible for study**

**2. Exclusion Criteria**

|  |  |
| --- | --- |
| Is the patient not physically or psychologically able to participate based on clinical judgment? | □1Yes □0 No |
| Is the patient’s pregnancy ectopic or molar? | □1Yes □0 No |

**If 1 or more of the above exclusion criteria is answered “yes” the patient is NOT eligible for study**

**3. Eligibility Determination**

The patient is eligible for the study. (All answers to inclusion criteria questions are Yes AND all answers to exclusion criteria are No.)

□1Yes □0 No

**4. Informed Consent**

Did the patient sign informed consent for participation? □1Yes □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? □1Yes □0 No

4.2 If no,

4.2a. Why not? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. Enrollment**

5.1 Was the patient enrolled? □1Yes □0 No

5.2 Patient identifier number: **\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_ 0**

(Site number: 1, 2…) (Patient number: 001,002 etc)