Attachment C1

Form Approved
OMB No. 0920-XXX
Exp. Date XX/XX/20XX

Today's date: _____/_____/_____
MM DD YYYY

ZIKV RNA Persistence (ZIRP): Pregnant Woman Screening Form

Clinic Information

Clinic name: _____

Municipality*:_____

Study site # (if applicable):_____

Patient Information

Last name: _____

First name: _____

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)