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CONGENITAL SYNDROME ASSOCIATED WITH ZIKA VIRUS INFECTION CASE INVESTIGATION

INITIAL DIAGNOSIS	
Initial Diagnosis/Notification: Congenital Syndrome Associated with Zika Virus Infection	
Date of Notification: DD/MM/YYYY	Date Investigation Started: DD/MM/YYYY
PATIENT'S DEMOGRAPHICS	
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Patient's ID Type: ◯ TRN ◯ Passport ◯ NIN	Patient's ID Number:
Sex Assigned at Birth: ◯ Male ◯ Female	Medical Record Number:
Date of Birth: DD/MM/YYYY	Age:
Country of Residence:	Parish (Jamaica):
House Number, Street Name:	
Landmark or directions to address:	Community:
Phone Number:	Email Address:
NEXT OF KIN	
First Name:	Last Name:
Next of Kin ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN	Patient's ID Number:
Phone number:	Email address:
Address: Lot/ Street/Community/Parish:	
Relationship to the Patient:	

◯ Mother	◯ Father	◯ Uncle	◯ Grandfather
◯ Guardian	◯ Brother	◯ Aunt	◯ Cousin
◯ Sister	◯ Grandmother	◯ Other	

CLINICAL PROFILE
Date Patient Seen: DD/MM/YYYY
Gestational Age at Birth:

Signs or Symptoms	Presence	Date of Diagnosis
Craniofacial disproportion		
Redundant scalp	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Other anthropometric disproportion	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Hypertonia or spasticity	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Irritability	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Epileptic seizures	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Visual impairment	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Auditory impairment	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Club feet	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Developmental delay	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Arthrogryposis	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Enlarged liver	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Enlarged spleen	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Glaucoma	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Cataracts	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Hearing impairment	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Jaundice	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Long bone radiolucency	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Meningoencephalitis	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY

Signs or Symptoms	Presence	Date of Diagnosis
Patent ductus arteriosus	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Peripheral pulmonary artery stenosis	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Pigmented retinopathy	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Purpura	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Other	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY

Infant Measurements

Measure	Value (units)	Date Measurement Taken
Birth weight		DD/MM/YYYY
Weight		DD/MM/YYYY
Weight for age Z-score		DD/MM/YYYY
Birth length		DD/MM/YYYY
Length		DD/MM/YYYY
Length for age Z-score		DD/MM/YYYY
Birth head circumference		DD/MM/YYYY
Head circumference		DD/MM/YYYY
Head circumference for age Z-score		DD/MM/YYYY

Relative head circumference for age:

◯ Normal head circumference	◯ Severe microcephaly
◯ Microcephaly	◯ Macrocephaly

Date of Diagnosis: DD/MM/YYYY

Relative size for age

◯ Normal for Age	◯ Small for Age
◯ Large for Age	

Date of Diagnosis: DD/MM/YYYY

Other problem or diagnosis:

HOSPITAL SUMMARY

Admitted to Hospital? ◯ Yes ◯ No ◯ Unknown	Date of Admission: DD/MM/YYYY	Date of Discharge: DD/MM/YYYY

Hospital: | Medical Record Number:

Admission Diagnosis

Admitted to Nursery: ◯ Yes ◯ No ◯ Unknown | Admitted to NICU: ◯ Yes ◯ No ◯ Unknown

Date of ICU Admission: DD/MM/YYYY | Date of ICU Discharge: DD/MM/YYYY

Vital Status (Outcome): ◯ Alive ◯ Dead	Date of Death: DD/MM/YYYY	Time of Death: __:__ AM/PM

Place of Death: ◯ Home ◯ DOA ◯ Ward ◯ ICU ◯ Other Specify, _________________

Date of Diagnosis: DD/MM/YYYY

Summary of Clinical Management:

DIAGNOSTIC INVESTIGATION SCREENING

Specimen - Collection Details				Specimen - Laboratory Details			
Test Type	**Specimen Type**	**Date Specimen Collected**	**Date Specimen Sent to Lab**	**Date/time received by laboratory**	**Adequacy for testing**	**Quantitative Test result**	**Test result**
Zika Virus		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown
Toxoplasmosis		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown
Rubella		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown
Herpes Simplex		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown
HIV		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown

Specimen - Collection Details				Specimen - Laboratory Details			
Test Type	**Specimen Type**	**Date Specimen Collected**	**Date Specimen Sent to Lab**	**Date/time received by laboratory**	**Adequacy for testing**	**Quantitative Test result**	**Test result**
Syphillis		*DD/MM/YYYY*	*DD/MM/YYYY*	*DD/MM/YYYY*	◯ Satisfactory - analysed ◯ Unsatisfactory-analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown
Dengue		*DD/MM/YYYY*	*DD/MM/YYYY*	*DD/MM/YYYY*	◯ Satisfactory - analysed ◯ Unsatisfactory-analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown
Other:		*DD/MM/YYYY*	*DD/MM/YYYY*	*DD/MM/YYYY*	◯ Satisfactory - analysed ◯ Unsatisfactory-analysed ◯ Unsatisfactory – not analysed		◯ Positive ◯ Indeterminate ◯ Negative ◯ Unknown

Laboratory Comments:

Is the sample being sent to an external lab? ◯ Yes ◯ No

◯ National Public Health Laboratory ◯ CARPHA ◯ Other

Specify Other Laboratory:

Imaging examination

Study	Done		Date of Study	Results
Cranial Ultrasound	◯ **Yes**	◯ **No**	DD/MM/YYYY	
MRI Brain	◯ **Yes**	◯ **No**	DD/MM/YYYY	
CT Brain	◯ **Yes**	◯ **No**	DD/MM/YYYY	
Ophthalmologic Evaluations	◯ **Yes**	◯ **No**	DD/MM/YYYY	
Auditory Tests	◯ **Yes**	◯ **No**	DD/MM/YYYY	

Findings of Imaging Studies

Findings	Present		
Cerebral hypoplasia	◯ Yes	◯ No	◯ Unknown
Hypoplasia or agenesis of the corpus callosum	◯ Yes	◯ No	◯ Unknown
Cerebral calcifications	◯ Yes	◯ No	◯ Unknown
Alterations in the cerebral ventricles	◯ Yes	◯ No	◯ Unknown
Abnormalities of the posterior fossa	◯ Yes	◯ No	◯ Unknown
Lissencechaly	◯ Yes	◯ No	◯ Unknown
Focal retinal pigment epithelium changes	◯ Yes	◯ No	◯ Unknown
Chorioretinal atrophy	◯ Yes	◯ No	◯ Unknown
Optic nerve hypoplasia	◯ Yes	◯ No	◯ Unknown
Iris colobomas	◯ Yes	◯ No	◯ Unknown

MOTHER'S INFORMATION	
ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN	ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Maiden Name:	Medical Record Number:
House Number, Street Name:	Parish (Jamaica):
Phone Number:	Email Address:
Occupation:	
Name of Workplace/School:	
Address of School/Workplace:	
Phone Number:	Email Address:
MOTHER'S ANTENATAL HISTORY	
LMP: DD/MM/YYYY	EDD: DD/MM/YYYY
Ultrasound EDD:	Gravida:
Parity:	Gestational Age at Delivery:
Multiple pregnancy: ◯ Yes ◯ No ◯ Unknown	Number of foetuses:
Place of delivery	
MOTHER'S EXPOSURE PROFILE	
Exposure to Zika: ◯Yes ◯No ◯Unknown	Patient Presenting with: ◯ Confirmed Zika ◯ Zika-like Illness
Gestational Age of Exposure:	Trimester: ◯ First ◯ Second ◯ Third
Did mother present with any of the following signs or symptoms during pregnancy?	

Signs or Symptoms	Presence	Date of Onset
Rash	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Fever	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Conjunctivitis	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Joint Pain	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY
Muscle Pain	◯ Yes ◯ No ◯ Unknown	DD/MM/YYYY

Is mother HIV positive?
◯Yes ◯ No ◯Unknown

Did mother have a reactive syphilis test (VDRL/TRUST)??
◯ Yes ◯No ◯Unknown

Description of Rash (if Applicable):

TRAVEL PROFILE

Are there other cases present in the case's community of residence? ◯ Yes ◯ No

Travelled in the last 3 weeks: ◯ Yes ◯ No ◯ Unknown

If travelled: ◯ Domestic Travel ◯ International Travel ◯ Domestic and International Travel

If international travel, fill out the table below:

Country Visited	City Visited	Accommodation	Date Arrived in Country	Date Departed Country
			DD/MM/YYYY	DD/MM/YYYY
			DD/MM/YYYY	DD/MM/YYYY
			DD/MM/YYYY	DD/MM/YYYY
			DD/MM/YYYY	DD/MM/YYYY

Date returned to Jamaica: DD/MM/YYYY

If local travel, fill out the table below:

Address	Parish	Date Arrived	Date Departed
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY

Date returned to home address: DD/MM/YYYY

Classification

Initial Diagnosis: Congenital Syndrome Associated with Zika Virus Infection

Final Diagnosis:

Case classification:

◯ Laboratory Confirmed	◯ Probable	◯ Suspected
◯ Pending	◯ Inconclusive	◯ Discarded

Reason for classification:

DEATH CLASSIFICATION

Did Congenital Zika contribution to patient’s death? ◯ Yes ◯ No ◯ Unknown

Immediate Cause:

Intermediate Cause:

Underlying Cause:

Investigator’s Comments:		
Investigator’s Details		
Date Investigation Completed: *DD/MM/YYYY*		
First Name:	Last Name:	
Professional Group:		
Phone number:	Email Address:	
Name of Institution:		
Parish:	Community:	
Office Number/Street Name:		
Health Region:		
Name of Parish MO(H):	Signature of MO(H)	Date signed by MO(H): *DD/MM/YYYY*