

ZIKA INVESTIGATION FORM

INITIAL DIAGNOSIS				
Initial Diagnosis/Notification: Zika				
Date of Notification: <i>DD/MM/YYYY</i>		Date Investigation Started: <i>DD/MM/YYYY</i>		
PATIENT'S DEMOGRAPHICS				
Patient's ID Type: <input type="radio"/> Driver's License <input type="radio"/> TRN <input type="radio"/> Passport <input type="radio"/> NIN		Patient's ID Number:		
First Name:		Middle Name(s):		
Last Name:		Pet Name(s):		
Sex Assigned at Birth: <input type="radio"/> Male <input type="radio"/> Female		Medical Record Number:		
Date of Birth: <i>DD/MM/YYYY</i>		Age:		
Country of Residence:		Parish (Jamaica):		
House Number, Street Name:				
Landmark or directions to address:		Community:		
Phone Number:		Email Address:		
CLINICAL PROFILE				
<input type="radio"/> History of Fever		<input type="radio"/> Recorded Fever		
Recorded temperature:	Duration (days):	Date of Onset: <i>DD/MM/YYYY</i>		
Signs or Symptoms	Presence			Date of Onset
Arthralgia	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Severe Arthralgia	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Right hand	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Left hand	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Right wrist	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Left wrist	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Right ankle	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Left ankle	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Right foot	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
- Left foot	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Arthritis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Location of Arthritis				
Myalgia	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Back pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Headache	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Nausea	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Mucosal bleeding	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Vomiting	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Asthenia (generalized weakness)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Skin Manifestations	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
Periarticular oedema	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>
	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	<i>DD/MM/YYYY</i>

Description of Skin Manifestation (if Applicable):

Medical History

Pre-existing Conditions

<input type="radio"/> Asthma	<input type="radio"/> Diabetes mellitus	<input type="radio"/> HIV/AIDS	<input type="radio"/> Malignancy
<input type="radio"/> Autoimmune	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension	<input type="radio"/> Sickle Cell Disease
<input type="radio"/> Chronic Obstructive Pulmonary Disease (COPD)	<input type="radio"/> Kidney disease	<input type="radio"/> Liver dysfunction	<input type="radio"/> Other Specify Other:

Pregnancy

Is Patient Pregnant: Yes No Unsure Not applicable

Gestational Age: _____ Trimester: First Second Third

EXPOSURE PROFILE

Has the person had contact with a confirmed Zika case in the last 3 weeks? Yes No Unknown

Date of Exposure: *DD/MM/YYYY* Comment: _____

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
			<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>
			<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>
			<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>
			<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>

Date returned to Jamaica: *DD/MM/YYYY*

If Local Travel, fill out the table below:

Address	Parish	Date Arrived	Date Departed
		<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>
		<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>
		<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>
		<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>

Date returned to home address: *DD/MM/YYYY*

SAMPLE AND LAB INFORMATION							
Blood Tests - Collection Details				Specimen - Laboratory Details			
Specimen Number	Test Name	Date Specimen Collected	Date Specimen Sent to Lab	Date/time received by laboratory	Adequacy for testing	Quantitative Test result	Test result
	<input type="radio"/> Virus Isolation <input type="radio"/> IgM ELISA <input type="radio"/> RT-PCR <input type="radio"/> Other: _____	<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>	<input type="radio"/> Satisfactory - analysed <input type="radio"/> Unsatisfactory- analysed <input type="radio"/> Unsatisfactory – not analysed		<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Indeterminate <input type="radio"/> Unknown
	<input type="radio"/> Virus Isolation <input type="radio"/> IgM ELISA <input type="radio"/> RT-PCR <input type="radio"/> Other: _____	<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>	<i>DD/MM/YYYY</i>	<input type="radio"/> Satisfactory - analysed <input type="radio"/> Unsatisfactory- analysed <input type="radio"/> Unsatisfactory – not analysed		<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Indeterminate <input type="radio"/> Unknown
Is the sample being sent to an external lab? <input type="radio"/> Yes <input type="radio"/> No							
<input type="radio"/> National Public Health Laboratory <input type="radio"/> CARPHA <input type="radio"/> Other							
Specify Other Laboratory:							

HOSPITAL SUMMARY

Admitted to Hospital? <input type="radio"/> Yes <input type="radio"/> No		Date of Admission: <i>DD/MM/YYYY</i>	Date of Discharge: <i>DD/MM/YYYY</i>
Hospital:		Medical Record Number:	
Vital Status (Outcome): <input type="radio"/> Alive <input type="radio"/> Dead		Date of Death: <i>DD/MM/YYYY</i>	Time of Death: __:__ AM/PM
Place of Death: <input type="radio"/> Home <input type="radio"/> DOA <input type="radio"/> Ward <input type="radio"/> ICU <input type="radio"/> Other, Specify: _____			

CLINICAL MANAGEMENT

Summary of Clinical Management:

Classification

Index Diagnosis: Zika	Final Diagnosis:
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Case classification:

<input type="radio"/> Laboratory Confirmed	<input type="radio"/> Probable	<input type="radio"/> Suspected
<input type="radio"/> Pending	<input type="radio"/> Inconclusive	<input type="radio"/> Discarded

Reason for classification:

Aetiology Category: Imported case Import-related cases Endemic /Local Transmission Unknown

Source country (If Imported or Import-Related):

DEATH CLASSIFICATION

Did Zika contribute to patient's death? Yes No Unknown

Immediate Cause:

Intermediate Cause:

Underlying Cause:

Investigator's Comments:

ENVIRONMENTAL SURVEY

Urban setting: Urban Peri-Urban Rural

Community planning: Planned Unplanned

Water supply: Piped Stored

Waste collection frequency: Frequent Infrequent

Mosquito population Aegypti Albopictus

Aedes Indices

Home Indices	Numerator	Denominator
Premises index (PI)		
Container index (CI)		
Breteau index (BI)		
School/Workplace Indices		
Premises index (PI)		
Container index (CI)		
Breteau index (BI)		

Investigator's Details	Public Health Inspector Details
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Date Investigation Completed: <i>DD/MM/YYYY</i>		Date Environmental Survey Completed: <i>DD/MM/YYYY</i>	
First Name:		First Name:	
Last Name		Last Name	
Professional Group:		Professional Group:	
Phone number:		Phone number:	
Email Address:		Email Address:	
Name of Institution:		Name of Institution:	
Community:		Community:	
Parish:		Parish:	
Office Number/Street Name:			
Health Region:			
Name of Parish MO(H):		Signature of MO(H)	Date signed by MO(H): <i>DD/MM/YYYY</i>