Philippine Integrated Disease Surveillance and Response

Annex B. Case Investigation Form

Zika Virus Disease

(ICD 10 Code: U06.9)

Version 2016

Region/Province/Municipality Name of Disease Reporting Unit:				Type: ☐ Public Hospital ☐Private Hospital Patient No. _____	
Date Admission:	*MM*	*DD*	*YY*	Name of the Investigator	
Date of Investigation:	*MM*	*DD*	*YY*	Email Address:	Contact Nos.:

I. PATIENT INFORMATION

_____
Last Name First Name Middle Name

Address: _____

Occupation: _____

Name of Workplace/School: _____

Date of Birth: ____/____/____ MM/DD/YYYY

Age: _____ Sex:

☐ Days ☐ Female
☐ Months ☐ Male
☐ Years

Contact Number: _____

II. CLINICAL DATA (For Suspect Case Class A)

Clinical Features	Y	N	Date of Onset MM / DD/ YYYY	Clinical features	Y	N	Date of Onset MM / DD/ YYYY
Fever+	☐	☐	____/____/____	Tingling sensations in the legs+	☐	☐	____/____/____
Skin Rash	☐	☐	____/____/____	Paralysis+	☐	☐	____/____/____
Myalgia+	☐	☐	____/____/____	Seizures	☐	☐	____/____/____
Asthenia (generalized weakness)+	☐	☐	____/____/____	Back Pain	☐	☐	____/____/____
Arthralgia+	☐	☐	____/____/____	Non-purulent Conjunctivitis	☐	☐	____/____/____
Arthralgia (joint pain) – Circle/list joints involved: Hand: R | L Wrist R | L Foot: R | L Ankle: R | L				Retro-orbital Pain			
Lower Limb Edema	☐	☐	____/____/____	Abdominal Pain	☐	☐	____/____/____
Periarticular Edema	☐	☐	____/____/____	Diarrhea+	☐	☐	____/____/____
Headache	☐	☐	____/____/____	Others (specify)			

+***Check the patient for signs and symptoms of Acute Flaccid Paralysis and Guillain-Barré Syndrome***

III. EXPOSURE AND TRAVEL HISTORY

	Y	N	Date MM / DD/ YYYY	Details
1. Has the patient travelled to a Zika fever endemic/epidemic area* within the past 2 weeks?	☐	☐	____/____/____	
2. Has the mother travelled to a Zika fever endemic/epidemic area during pregnancy?	☐	☐	____/____/____	
3. Has the patient had sexual contact with a Zika fever case within the past 2 weeks?	☐	☐	____/____/____	
4. Has the patient received blood or blood products within the previous 30 days prior to symptom onset?	☐	☐	____/____/____	
5. Does the patient have a history of Guillain-Barre syndrome (GBS) ?	☐	☐	____/____/____	

Places Visited:	Any Fever? Y/N		Arrival MM / DD/ YYYY	Departure MM / DD/ YYYY	Received Treatment? Y/N		Specify:
1.	☐	☐	____/____/____	____/____/____	☐	☐	
2.	☐	☐	____/____/____	____/____/____	☐	☐	

Countries and Territories with reported confirmed autochthonous cases of Zika Virus Infection in the past nine months

American Samoa, Aruba, Barbados, Bolivia, Bonaire, Brazil, Cape Verde, Colombia, Costa Rica, Curacao, Dominican Republic, Ecuador, El Salvador, Fiji, French Guiana, Guadeloupe, Guatemala, Guyana, Haiti, Honduras, Jamaica, Maldives, Marshall Islands, Martinique, Mexico, New Caledonia (France), Nicaragua, Panama, Paraguay, Puerto Rico, Philippines, Saint Martin, Saint Vincent and the Grenadines, Samoa, Sint Maarten, Solomon Islands, Suriname, Thailand, Tonga, Trinidad and Tobago, Vanuatu, Venezuela ,US Virgin Islands

Philippine Integrated Disease Surveillance and Response

Annex B. Case Investigation Form

Zika Virus Disease

(ICD 10 Code: U06.9)

Version 2016

IV. INFANT/FETAL INFORMATION (For Suspect Case Class B and C)

Anthropometric Measurement		Y	N	Remarks
Type of birth ☐ Livebirth ☐ Stillbirth ☐ Fetus less than 20 weeks gestation	**Neonate/Infant abnormalities (specify)**			
Length:	a. Head circumference at birth (in centimeters)			
Birth weight:	b. Head circumference at birth < third percentile	☐	☐	
Chest Circumference:	c. Head circumference 24 hours after birth: (in centimeters, to one decimal point)			
Apgar Score:	d. Head circumference 24 hours after birth < third percentile	☐	☐	
Ballard Score:	e. Result of neuroimaging study (brain echography; MRI; CT): (with/without findings)	☐	☐	
Age of Gestation (AOG):	f. Does the newborn present any other congenital abnormality?	☐	☐	
Birth Complications ☐ Respiratory Distress ☐ Sepsis ☐ Meningitis ☐ Others_____ Contact number: _____	g. In the case of a stillbirth or live newborn that dies within the first hours after birth: Was an autopsy performed?	☐	☐	

Maternal Information

_____
Last Name First Name Middle Name

Address: _____

Attending Physician's/health Care Provider's Name: _____

Contact number: _____

Age: _____

Date of Birth: ____/____/____ MM/DD/YYYY

Date of last menstrual period: ___/___/___MM/DD/YYYY

Estimated Date of Delivery: ____/____/____MM/DD/YYYY

Health History

Gravidity:_____ Parity:_____

☐ Smoking
No. of sticks/packs per day_____
☐ Heart Disease
☐ Stroke
☐ Obesity
☐ Malnutrition
☐ Drug Abuse
☐ Alcohol
No. of bottles consumed per day_____
☐ Medications_____
☐ Exposure to mercury
If Yes, give details_____

☐ Others *(please specify):* _____

Chronic and Acute Conditions During Pregnancy

☐ Diabetes
☐ Type 1 ☐ Type 2

☐ Epilepsy
Years_____ Medications:_____

☐ Infections *(please specify):* _____
Year acquired:_____

Others *(please specify):* _____

Pregnancy Complications:

☐ Placental Abruption
☐ Ectopic Pregnancy
☐ Preterm Labor
☐ Gestational Diabetes:

Prenatal Testing

	Date Tested MM / DD/ YYYY	Results Received MM / DD/ YYYY	Findings:
1. Ultrasound	____/____/____	____/____/____	
2. Amniocentesis	____/____/____	____/____/____	
3. Glucose Tolerance Test	____/____/____	____/____/____	
4. Hepatitis	____/____/____	____/____/____	
5. Others	____/____/____	____/____/____	

V. LABORATORY INFORMATION

Sample Type	Date Collected MM / DD/ YYYY	Date sent to testing lab MM / DD/ YYYY	Date received in Lab MM / DD/ YYYY	Test Done	Results
Blood (Acute phase)	__/___/___	__/___/___	__/___/___		
Blood (Convalescent phase)	__/___/___	__/___/___	__/___/___		
CSF	__/___/___	__/___/___	__/___/___		
Amniotic Fluid samples (For pregnant women with fetal microcephaly)	__/___/___	__/___/___	__/___/___		
Cord Blood	__/___/___	__/___/___	__/___/___		
Placenta	__/___/___	__/___/___	__/___/___		
Urine	__/___/___	__/___/___	__/___/___		
NPS/OPS					

VI. DIAGNOSTIC INFORMATION

Neuro-imaging study	Date Performed MM / DD/ YYYY	Date Received MM / DD/ YYYY	Result
1. Cranial Ultrasound	__/___/___	__/___/___	
2. CT Scan	__/___/___	__/___/___	
3. MRI Scan	__/___/___	__/___/___	
4. Others _____			

VII. OUTCOME

☐ Alive	☐ Died
Date Discharged: ____/____/____ MM/DD/YYYY	*Date Died:* ___/____/____ MM/DD/YYYY

VIII. FINAL CASE CLASSIFICATION:

Suspected Case	Confirmed Case	Discarded Case
☐ Imported	☐ Imported	☐ Yes
☐ Autochthonous	☐ Autochthonous	☐ No