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: ____/____/____

Age: _____ Sex:

☐ Days ☐ Female
☐ Months ☐ Male
☐ Years

II. EXPOSURE AND TRAVEL HISTORY

	Y	N	Date	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 been in 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?	☐	☐	____/____/____	

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

III. CLINICAL DATA

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***

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

American Samoa, Aruba, Bardados, Bolivia, Bonaire, Brazil, Cape Verde, Colombia, Costa Rica, Curacao, Dominican Republic, Ecuador, El Salvador, Fiji, French Guiana, Guadaloupe, Guatemala, Guyana, Haiti, Honduras, Jamaica, Maldives, Mashall 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

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IV. LABORATORY INFORMATION

Sample Type	Date Collected	Date sent to testing lab	Date received in Lab	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					

V. DIAGNOSTIC INFORMATION

Test	Date performed	Date received	Result	Comment
1. Neuro-imaging study:	__/___/___	__/___/___		
2. Others: _____	__/___/___	__/___/___		

VI. ADDITIONAL CLINICAL FEATURES:

	Y	N	Remarks
1. Pregnant	☐	☐	
a. Gravidity			
b. Parity			
2. Fetal abnormalities (specify)			
a. Fetal Death in Utero	☐	☐	
b. Microcephaly	☐	☐	
c. Others			
3. Recent Vaccination			
a. If Yes, <6 weeks	☐	☐	
b. >6 weeks	☐	☐	
c. Type of Vaccine given			
Date given:	____/____/____		
d. Adverse Reaction			
Date onset:	____/____/____		

	Y	N	Remarks
5. Neonate/Infant abnormalities (specify)			
a. Head circumference at birth (in centimeters)			
b. Head circumference at birth < third percentile	☐	☐	
c. Head circumference 24 hours after birth: (in centimeters, to one decimal point)			
d. Head circumference 24 hours after birth < third percentile	☐	☐	
e. Result of neuroimaging study (brain echography; MRI; CT): (with/without findings)	☐	☐	
f. Does the newborn present any other congenital abnormality?	☐	☐	
g. In the case of a stillbirth or live newborn that dies within the first hours after birth: Was an autopsy performed?	☐	☐	

4. Anthropometric Measurement
Length:
Weight:
Chest Circumference:
Apgar Score:
Ballard Score:
Age of Gestation (AOG):

VII. FINAL CASE CLASSIFICATION:

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

VIII. OUTCOME

☐ Alive	☐ Died
Date Discharged: ____/____/____	*Date Died:* ____/____/____