UN Medical Services Division: Case Report Form for Zika & Related Conditions

Clinical Diagnosis: _____
Date Report Submitted to MSD (dd/mm/yy): ____/____/____

Patient Information:
Patient First Name: _____ Last Name: _____ Nationality: _____
Date of Birth (dd/mm/yy): ____/____/____ Age: ___ Sex: ☐M ☐ F
If Patient is Child, Guardian First Name: _____ Guardian Last Name: _____
Patient Home Address: _____
Patient Phone Number: _____ Duty Station: _____Organization: _____
Patient UN Dept./Office: _____ Functional Title: _____ Index No.: _____
Description of Job Duties: _____

History of Illness:
Asymptomatic: ☐Yes ☐No
If symptomatic, date of onset of illness (dd/mm/yy): ____/____/____
Date diagnosed (dd/mm/yy): ____/____/____
Length of illness (days): _____
Incubation period (hours or days) if known_____
Describe signs and symptoms and clinical course:
_____
_____
_____
Rash ☐Yes ☐No ☐Unknown Please describe rash if present:
_____
Measured Fever (>38°C or 100°F) ☐Yes ☐No ☐Unknown Max Temp: ____
Subjective Fever ☐Yes ☐No ☐Unknown
Joint Pain ☐Yes ☐No ☐Unknown
Joint Swelling ☐Yes ☐No ☐Unknown
Eye redness ☐Yes ☐No ☐Unknown
Eye pain ☐Yes ☐No ☐Unknown
Headache ☐Yes ☐No ☐Unknown
Muscle weakness ☐Yes ☐No ☐Unknown
Muscle pain ☐Yes ☐No ☐Unknown
Extreme fatigue ☐Yes ☐No ☐Unknown
Nausea/Vomiting/Diarrhea ☐Yes ☐No ☐Unknown
Was Guillain-Barré Syndrome identified? ☐Yes ☐No ☐Unknown
If yes, date diagnosed (dd/mm/yy): ____/____/____
Was the patient hospitalized? ☐Yes ☐No ☐Unknown
If yes, name and address of hospital: _____
_____
If yes, admission date (dd/mm/yy): ____/____/____
discharge date (dd/mm/yy): ____/____/____
Was the patient admitted to the intensive case unit? ☐Yes ☐No ☐Unknown
Did the patient require mechanical ventilation? ☐Yes ☐No ☐Unknown
Outcome of case: ☐Died ☐Survived ☐Unknown
If fatal, date of death (dd/mm/yy): ____/____/____
If fatal, cause of death (specify): _____

Was your Organization or Agency notified of this patient?
☐Yes ☐No ☐Unknown
If yes, date notified (dd/mm/yy): ____/____/____

Medical History:
Does the case-patient have any past medical history, including chronic/immunosuppressive conditions? ☐Yes ☐No ☐Unknown
If Yes, please specify: _____
_____
_____
_____
_____
_____
History of mosquito-borne illness? ☐Yes ☐No ☐Unknown
If yes which one? ☐Dengue ☐Yellow Fever ☐JE ☐WNV
☐Others_____
Took malaria prophylaxis? ☐Yes ☐No ☐Unknown
*If yes, which prophylaxis?*_____
Date started (dd/mm/yy): ____/____/____
Date ended (dd/mm/yy): ____/____/____

Vaccination History:
Yellow Fever ☐Yes ☐No ☐Unknown Date:_____
Japanese Encephalitis ☐Yes ☐No ☐Unknown Date:_____
Tick-borne Encephalitis ☐Yes ☐No ☐Unknown Date:_____

Diagnostic Tests:
Please describe type of specimen, date collected, type of test, results, and laboratory name and address:
_____
_____
_____
_____

Treatment:
Please describe date and type of treatment provided to patient:
_____
_____
_____
_____
_____

Pregnancy Information:
Last normal menstrual period (dd/mm/yy): ____/____/____ Currently pregnant? ☐Yes ☐No ☐Unknown
If currently pregnant, how far along (in weeks)?: _____ Estimated delivery date (dd/mm/yy): ____/____/____
If not pregnant or unknown, please skip to next section.
Was microcephaly detected on fetal ultrasound? ☐Yes ☐No ☐Unknown
Were intracranial calcifications detected on fetal ultrasound? ☐Yes ☐No ☐Unknown
Planned hospital delivery? ☐Yes ☐No ☐Unknown Name of hospital:_____
Actual Delivery Date (dd/mm/yy): ____/____/____

For MSD's Use Only:
Case ID #: _____
Classification of Case: Suspect/Probable/Confirmed/Not a Case

Pregnancy outcome? ☐Live birth ☐Stillborn (>20 weeks) ☐Miscarriage (<20 weeks) ☐Termination ☐Unknown

Risk Factor Assessment – within 30 days of onset of symptoms:

Sexual contact with anyone suspected to have Zika or with a person who travelled to a Zika-affected area? ☐Yes ☐No ☐Unknown

Does the patient have known mosquito exposure? ☐Yes ☐No ☐Unknown

If yes, date of exposure (dd/mm/yy): ____/____/____

Exposure location: _____

Did the patient travel? ☐Yes ☐No travel history within the past 2 weeks ☐Unknown

If yes, please specify travel destination(s) and itinerary:

Blood and Blood Products:

Within 30 days prior to onset of symptoms, did the patient receive blood or blood products? ☐Yes ☐No ☐Unknown

Within 30 days prior to onset of symptoms, did the patient receive organ/tissue transplant? ☐Yes ☐No ☐Unknown

Additional comments:

Reporter Information:

Date Report Submitted (dd/mm/yy): ____/____/____ Reporter First Name: _____ Last Name: _____

Duty Station: _____ Organisation: _____ Dept/Office: _____Title: _____

Phone Number: _____ Fax Number: _____ E-Mail: _____

Name of Treating Physician: _____ Physician Phone: _____ Physician Email: _____

How long did this case report take to complete (minutes)? _____

Please submit completed forms to msdpublichealth@un.org or fax to: +917-367-0656.
Please attach any available medical records to this form.
For any questions, please contact MSD at msdpublichealth@un.org or +1-917-353-5387

For MSD's Use Only:

Case ID #: _____

Classification of Case: Suspect/Probable/Confirmed/Not a Case