MHHLS Case ID number _________

Manitoba
Health, Healthy Living and Seniors

ZIKA VIRUS CASE REPORT FORM

Please complete for confirmed cases only and forward by fax to 204-940-2690

CASE INFORMATION

Given Name ______________________________ Surname ________________________________

PHIN (9digits) ____________________________ Birthdate (YYYY/MM/DD) __________________

Sex: M/F/Unknown RHA _____________

Has the patient been advised that general (non-identifiable) information regarding their case may be reported in a public announcement? Yes/No/Unknown

CLINICAL DETAILS

☐ Asymptomatic **OR** Date of symptom onset (YYYY/MM/DD) ________________

Symptoms (check all that apply):

☐ Rash ☐ Elevated temperature ☐ Arthralgia ☐ Myalgia
☐ Headache ☐ Non-purulent conjunctivitis ☐ Other (specify)____________________

Was case hospitalized? Yes/No/Unknown Name/location of hospital _________________________

Dates of hospitalization (YYYY/MM/DD) From______________________to _______________________

Severe outcome: Yes/No/Unknown If yes, specify: ____

Pregnant? Yes/No/Unknown If yes, weeks of gestation _________________________
If yes, date of last menstrual period (YYYY/MM/DD) _________________

If yes, outcome of pregnancy:

☐ Healthy birth
☐ Congenital Anomaly (specify) _________________
☐ Fetal death/still birth
☐ Spontaneous Abortion
☐ Other (specify) ____________________________

EXPOSURE DETAILS

Exposure period starts 12 days prior to symptom onset
Viraemic period is symptom onset date plus 7 days

Travel history during exposure and viraemic periods: Yes/No/Unknown
If yes:

Place (Country/City)	Dates (from –to)	Presence of mosquitoes noted (Y/N)

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Likely place of acquisition: _______________________

If no travel history (locally acquired):
Did case have sexual contact during exposure period with an individual who traveled to a Zika infected area within the 8 weeks? Yes/No/Unknown

Did case receive a blood transfusion within the last 12 days? Yes/No/Unknown

Additional details:

LABORATORY:

Date of specimen collection (YYYY/MM/DD) ____________________

Date case reported to MHHLS (YYYY/MM/DD) __________________

Laboratory test (check all that apply):
☐ RT-PCR ☐ IgM ELISA ☐ PRNT

Additional comments:

REPORTING INFORMATION:

Form completed by (please print) _____________________________

Position ____

Organization/Health Unit/Regional Health Authority

Telephone ______________________