Marin Zika Virus Screening Form

REQUESTING PHYSICIAN

Date CDCU Notified ___/___/_____
☐ Unk

Staff: _____

Last Name _____ First Name _____ Title: _____

Hospital/Facility Name _____

Phone: ( ) _____ Pager: ( ) _____ Fax: ( ) _____

Comments/Notes: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name_____

DOB ____/____/____ ☐ Unk Age:_____ Sex: ☐ Male ☐ Female ☐ Unk MR#_____

Address_____City_____State_____Zip_____

Home Phone: _____ Cell: _____ Work: _____ Email Address: _____

OOJ? ☐ Yes ☐ No ☐ Unk if yes, jurisdiction:_____

CRITERIA FOR TESTING ☐ Meets Both Travel & Clinical Criteria ☐ Does Not Meet Criteria

Testing Criteria: patient with travel history or residence to area(s) where Zika is circulating AND meets one of the following:

- Report ≥1 of the following symptoms: fever, maculopapular rash, or joint pain*, during or within 2 weeks of travel OR
  *If other symptoms, consult with MD/RN
- Fetus/infant with microcephaly and/or intracranial calcifications

1. TRAVEL INFORMATION

Travelled to/lived in Zika circulating areas*? ☐ Yes ☐ No ☐ Unk

If yes, specify:

Location: _____ Dates: _____
Location: _____ Dates: _____
Location: _____ Dates: _____

***Countries of concern** (as of 1/22/2016, 1pm):
Barbados, Bolivia, Brazil,
Cape Verde, Colombia,
Ecuador, El Salvador,
French Guiana,
Guadeloupe, Guatemala, Guyana,
Haiti, Honduras,
Martinique, Mexico,
Panama, Paraguay, Puerto Rico,
Saint Martin, Samoa, Suriname,
Venezuela

*Please check CDC website for updated list of countries
*If the country is not listed, please consult with MD/RN

2. CLINICAL INFORMATION

Symptomatic: ☐ Yes ☐ No ☐ Unk
Date of Symptom Onset: ___/___/_____ ☐ Unk
Date of last symptoms: ___/___/_____ ☐ Unk

Signs and Symptoms:

Fever ☐Yes ☐ No ☐ Unk
Max Temp: _____ ☐C ☐F

Maculopapular Rash ☐Yes ☐ No ☐ Unk
If yes, describe: _____

Joint Pain ☐Yes ☐ No ☐ Unk

Conjunctivitis (red eye) ☐Yes ☐ No ☐ Unk

Other symptoms ☐Yes ☐ No ☐ Unk
If yes, specify: _____

FOR PREGNANT/POSTPARTUM WOMEN:

Pregnant while traveling? ☐ Yes ☐ No ☐ Unk

Does ☐ fetus ☐ infant have:
Microcephaly? ☐ Yes ☐ No ☐ Unk

Intracranial calcification? ☐ Yes ☐ No ☐ Unk

*For other abnormalities, please consult with MD/RN