MINISTRY OF HEALTH

JAMAICA

CONGENITAL SYNDROME ASSOCIATED WITH ZIKA VIRUS INFECTION
CASE INVESTIGATION FORM

Reporting Centre: Date of Report / / (dd/mmm/yyyy)

1. Patient (Infant) Information

FIRST NAME:	Last Name:
Sex: Male Female (circle the one that applies)	D.O.B: / / (dd/mmm/yyyy)

2. Mother's Information

FIRST NAME:		Last Name:
Address Phone #		D.O.B: / / (dd/mmm/yyyy) Age in years:
Community (STATIN):	PARISH	Occupation
LMP: / / (dd/mmm/yyyy)	EDD: / / (dd/mmm/yyyy)	Gravida: Para:
Ultrasound: EDD	Gestational Age at Birth (Obstetrician's Recommendation): ___ ___ $^{+}$--/40	
Multiple Pregnancy: Yes/ No	If yes, give number:	

A. Mother's Antenatal History (Date of onset: dd/mmm/yyyy, if exact date is unknown give the best estimate)

Rash: Yes □ No □ Date of Onset ___/___/_____	Describe the rash or other clinical features:
Fever: Yes □ No □ Date of Onset ___/___/_____	
Conjunctivitis: Yes□ No□ Date of Onset ___/___/_____	
Joint Pain: Yes □ No □ Date of Onset ___/___/_____	
Muscle Pain: Yes□ No□ Date of Onset ___/___/_____	
HIV Status:	**Syphilis Status:**

B. Infant's Anthropometric Findings

Measurements	Date: ___/___/_____		Date: ___/___/_____		Date: ___/___/_____	
Gestational Age:	___ ___ $^{+}$---/40		___ ___ $^{+}$---/40		___ ___ $^{+}$---/40	
Compare to Standard Charts		Circle one that applies		Circle one that applies		Circle one that applies
Head Circumference (cm)	__ __ . __	<-3| <-2| Normal	__ __ . __	<-3| <-2| Normal	__ __ . __	<-3| <-2| Normal
Weight (kg)	__ __.__ __	<-3| <-2| Normal	__ __.__ __	<-3| <-2| Normal	__ __.__ __	<-3| <-2| Normal
Length (cm)	__ __ . __	<-3| <-2| Normal	__ __ . __	<-3| <-2| Normal	__ __ . __	<-3| <-2| Normal

Classification (*Circle one*): Normal | Small for Gestational Age | Microcephaly | Severe Microcephaly

C. Infant's Clinical Findings (Describe)

1. Cranial-facial disproportion	**Yes | No**	
• Redundant scalp	**Yes | No**	
2. Other Anthropometric Disproportion	**Yes | No**	
3. Hypertonia or Spasticity	**Yes | No**	
4. Irritability	**Yes | No**	
5. Epileptic Seizures	**Yes | No**	
6. Visual Impairment	**Yes | No**	
7. Auditory Impairment	**Yes | No**	
8. Club feet	**Yes | No**	
9. Arthrogryposis	**Yes | No**	
10. Others (specify)		

Name: _____ Date of Birth ___/___/_____

D. INVESTIGATIONS & RESULTS

	Y / N	Date done/ received (dd/mmm/yyyy)	Describe Findings
1. Cranial Ultrasound	□ | □	___/___/___	
2. MRI Brain	□ | □	___/___/___	
3. CT Brain	□ | □	___/___/___	
4. Ophthalmologic evaluation	□ | □	___/___/___	
5. Auditory Test	□ | □	___/___/___	

Findings (answer all)

-Cerebral hypoplasia	**Yes | No**	-Lissencephaly	**Yes | No**
-Hypoplasia or agenesis of the corpus callosum	**Yes | No**	-Focal retinal pigment epithelium changes	**Yes | No**
-Cerebral calcifications	**Yes | No**	-Chorioretinal atrophy	**Yes | No**
-Alterations in the cerebral ventricles	**Yes | No**	-Optic nerve hypoplasia	**Yes | No**
-Abnormalities of the posterior fossa	**Yes | No**	- Iris colobomas	**Yes | No**

	Date Collected dd/mmm/yyyy	Results
a. Toxoplasmosis	___/___/___	
b. Rubella	___/___/___	
c. Herpes Simplex Virus	___/___/___	
d. HIV	___/___/___	
e. Syphilis	___/___/___	
f. Zika virus	___/___/___	
1) Blood: Zika PCR	___/___/___	
2) Urine: Zika PCR	___/___/___	
3) Blood: Zika IgM	___/___/___	
g. Blood: Dengue IgM	___/___/___	

E. OUTCOME

	Y / N	Date (dd/mmm/yyyy)	Comments
a. Nursery Admission	□ | □	____/_____/____	
b. NCU/ICU Admission	□ | □	____/_____/____	
c. Discharge Home	□ | □	____/_____/____	
d. Died	□ | □	____/_____/____	

F. Classification: Congenital Syndrome Associated with Zika Virus Infection

Circle One: **Not Suspected | Suspected | Probable | Confirmed | Unable to Classify**

Reason for the classification:

Medical Officer (Health)

Name: _____ **Signature:** _____

Date: _____