Zika Virus Disease Testing Request

Please complete this form and fax to (707) 299-4479. Specimens will not be tested unless this form is completed.

REPORTER/ REQUESTOR			
Date of Request:			
Name of Requesting Provider:		Facility:	
Telephone:		Fax:	
Pager/Cell:		Email:	
Address:		City:	Zip Code:
Name of person completing form (if not provider):			
Telephone:		Email:	

PATIENT DEMOGRAPHICS			
Name:	Sex: ☐F ☐M	DOB:	Age:
Patient Address:		City:	Zip:
Telephone:	Cell:	Email:	

CLINICAL INFORMATION (Please complete all information)		
Asymptomatic: ☐Y ☐N	If yes, first onset date:	Duration of illness: to
Fever: ☐Y ☐N	If yes, date of onset:	Temp: F/C
Joint pain/Swelling: ☐Y ☐N	If yes, date of onset:	
Conjunctivitis: ☐Y ☐N	If yes, date of onset:	
Maculopapular rash: ☐Y ☐N	If yes, date of onset:	
Pregnant: ☐Y☐N	If yes, number of weeks gestation/EDD:	
If pregnant, fetal ultrasound done: ☐Y ☐N		
Initial dating ultrasound: ☐Y ☐N Date:	Microcephaly: ☐Y ☐N	
Formal ultrasound: ☐Y ☐N Date:	Intracranial calcification: ☐Y ☐N	

History of	**Received**
Dengue Fever: ☐Y ☐N	Yellow Fever vaccine: ☐Y ☐N
West Nile Virus: ☐Y ☐N	Japanese Encephalitis vaccine: ☐Y ☐N
St. Louis Encephalitis infection: ☐Y ☐N	

EPIDEMIOLOGIC INFORMATION (Please answer all questions)

Traveled to area with Zika Virus transmission: ☐Y ☐N (see http://wwwnc.cdc.gov/travel/notices)

Sexual partner traveled to area with Zika Virus transmission and was symptomatic: ☐Y ☐N

Dates of travel					
From	To	Country	Regions	Cities	Mosquito bites?
					☐Y ☐N
					☐Y ☐N
					☐Y ☐N
					☐Y ☐N
					☐Y ☐N
					☐Y ☐N

Mosquito bites after symptom onset: ☐Y ☐N

If yes, locations (streets, cities, states)	

Special Specimen Collection Instructions

INFANT DEMOGRAPHICS		
Name:	Sex: ▣F ☐M	DOB:
Physical evidence of microcephaly: ☐Y ▣N		

Specimen	Date Collected	Time Collected	Preferred Amount	Container	Storage and Shipment Conditions
Serum			≥2 ml (one tube preferred)	red or tiger top tube	cold
Cord Blood			0.5-1 ml	sterile cryovial	cold or frozen
Placental			0.5-1.0 cm	sterile container	2 specimens: a.) cold formalin fixed and b.) frozen tissues
Cord Tissue			0.5-1.0 cm	sterile container	2 specimens: a.) cold formalin fixed and b.) frozen tissues
CSF			≥1 ml	sterile cryovial	cold
Urine			3-5 ml	15 ml conical tube	cold
Amniotic Fluid			≥1 ml	sterile cryovial	frozen