

Approved by:
Public Health Official Name/Date

In order for testing to be considered, **ALL** fields must be completed.

Report Date:

Patient Information:

Last name:		First Name:		MI:	
DOB: _____ / _____ / _____		Age: _____		Sex: Male Female	
Street Address:		Race: White Black Asian		American Indian/Alaskan Native Pacific Islander Other: Ethnicity: Hispanic or Latino Not Hispanic or Latino	
City:		State:		Zip: _____ County: _____	
Specimen Source (serum/urine/other):		Collection Date:		Patient ID:	

Patient's Provider Information:

Name:							
Street Address:		City:		State:		Zip Code:	
Telephone:		Fax:		Submitting Lab Name and Phone (if not provider):			

Reason for Testing and Travel History: All information must be completed or testing will **NOT** be performed

<input type="checkbox"/> Patient traveled to Zika-affected area Other: _____	Patient is symptomatic and did not travel to Zika-affected area, but had sexual contact with a person who did travel to affected area.	<input type="checkbox"/> Patient is symptomatic and did not travel to Zika-affected area, but is a household contact of a person who did travel to affected area.
<input type="checkbox"/> Patient's sexual partner traveled to Zika-affected area. Last date of unprotected sex: _____ / _____ / _____	Partner was symptomatic? Yes No Partner had mosquito bite(s)? Yes No	Travel Country (or countries for patient / patient's partner):
Travel Dates (for patient/patient's partner):	_____ / _____ / _____ to _____ / _____ / _____	

Clinical Information: All information must be completed or testing will **NOT** be performed

Pregnancy Status (if female)	Yes	No	Gestational Age:		EDD:		
Has patient experienced any symptoms?	Yes	No	Date of Onset: _____ / _____ / _____				
Fever (≥38°C or 100°F)	Yes	No	Unknown	Arthralgia	Yes	No	Unknown
Conjunctivitis	Yes	No	Unknown	Rash	Yes	No	Unknown
Mosquito Bite	Yes	No	Unknown	Guillain-Barre syndrome	Yes	No	Unknown
Other: (List)							
Ever vaccinated for:	<input type="checkbox"/> Yellow fever <input type="checkbox"/> Japanese encephalitis <input type="checkbox"/> Tickborne encephalitis <input type="checkbox"/> Dengue fever						
Past history of Arbovirus infection (such as West Nile or dengue):							

For submissions for Philadelphia residents and from Philadelphia healthcare providers, call (215) 685-6742 and fax this form to (215) 238 6947 for testing approval. If needed, specimen transport to the Bureau of Laboratories can also be arranged.

For more information visit: <https://hip.phila.gov/DiseaseControlGuidance/DiseasesConditions/Arboviruses/Zika>