pennsylvania
DEPARTMENT OF HEALTH

Zika Virus Laboratory Submission Form

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 ☐	Telephone:
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

☐ 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.	☐ 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.
☐ 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:	☐ Yellow fever		☐ Japanese encephalitis		☐ Tickborne encephalitis		☐ 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