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| CDRSS #: \_\_\_\_\_\_\_\_\_\_\_\_\_ **NJDOH ZIKA VIRUS PATIENT INFORMATION WORKSHEET** |
| To request Zika Virus testing at PHEL, providers can call the patient’s local health department (LHD)or fax this completed form to request approval. Please review NJDOH guidance on current criteria for testing at: <http://www.nj.gov/health/cd/zika/techinfo.shtml>. Review CDC’s Zika Travel Information page to determine if your patient traveled to an area experiencing Zika transmission: <http://www.cdc.gov/zika/geo/>**Steps: 1) Fax the completed worksheet to the local health department (LHD) where the patient resides:** [**www.localhealth.nj.gov/**](http://www.localhealth.nj.gov/) **2) If approved, the LHD will fax SRD-1 form to your office along with instructions for specimen collection.**  |
| Patient Name (Last name, First name) | Date of Birth**\_\_\_\_ /\_\_\_\_ / \_\_\_\_\_** | Patient Sex |  |
| * Male
 | * Female
 |
| Patient Address City State Zip Code | Telephone Number( ) - |
| **Zika Exposure History (select all that apply)** |
| * Travel to area with Zika
 | Travel location(s): | Travel dates: | From: \_\_\_\_ /\_\_\_\_ / \_\_\_\_  | To:**\_\_\_\_ /\_\_\_\_ /\_\_\_\_** |
| * Unprotected sexual contact with Zika exposed partner
 | Date of first and last unprotected sexual contact with Zika exposed partner: | First \_\_\_\_ /\_\_\_\_ / \_\_\_\_  | Last:**\_\_\_\_ /\_\_\_\_ /\_\_\_\_** |
|  | Sexual partner’s travel location(s), *if applicable*: | Sexual partner’s travel dates: | From: \_\_\_\_ /\_\_\_\_ / \_\_\_\_\_  | To:**\_\_\_ /\_\_\_\_ / \_\_\_\_\_**  |
| * Congenital/Perinatal
 | * Laboratory/Healthcare
 | * Other Exposure (*specify*)
 | Exposure dates: | From:\_\_\_\_ /\_\_\_\_ / \_\_\_\_\_  | To:**\_\_\_ /\_\_\_\_ / \_\_\_\_\_**  |
| * Blood Transfusion
 | * Organ Recipient
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is the patient pregnant? | * No
 | * Yes **IF PREGNANT, estimated date of delivery (EDD):**
 | \_\_\_\_\_ / \_\_\_\_\_/ ­­­­\_\_\_\_\_ |
| Symptom Status | * Currently symptomatic
 | * Recovered /Formerly symptomatic
 | * Asymptomatic
 |
| **List all signs and symptoms with onset/resolution dates:**  | **Other Symptoms** (e.g., Headache, Myalgia,  |
|  | Onset Date *(dd/mm/yy)* | Resolution Date *(dd/mm/yy)* | Eye pain, etc.):  |
| * Fever
 | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ |
| * Rash
 | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ |  |
| * Conjunctivitis
 | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ | Comments (*if applicable)* |
| * Arthralgia (joint pain)
 | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ |  |
| * Neurological symptoms

(*specify)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_ / ­­­­\_\_\_\_\_\_\_ |
| **Immunization history and year of immunization if known:** |
| * Yellow Fever Vaccine \_\_\_\_\_\_\_\_
 | * Japanese Encephalitis Vaccine \_\_\_\_\_\_\_\_
 | * Tickborne Encephalitis Vaccine \_\_\_\_\_\_\_
 |
| **Previous history (year) of flavivirus/arboviral disease**  |
| * West Nile Virus \_\_\_\_\_\_\_\_
 | * Chikungunya Virus \_\_\_\_\_\_\_\_
 | * Other flavivirus/arboviral disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Dengue Virus \_\_\_\_\_\_\_\_
 | * Powassan Virus \_\_\_\_\_\_\_\_
 |   |
| **Submitter Information (Physician who is ordering Zika test)** |
| Name of Health Care Provider | Patient ID Number |
| Institution Name | Address |
| Phone( ) - | Fax (to receive test results)( ) - | E-mail Address: |
| Point of Contact if not Provider | **Lab Name (where the patient will be go to have their blood drawn)** |

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