NJDOH ZIKA VIRUS PATIENT INFORMATION WORKSHEET

CDRSS #: _____

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/
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*) _____
☐ Blood Transfusion ☐ Organ Recipient

Exposure dates: From: ___/___/____ To: ___/___/____

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:

	Onset Date *(dd/mm/yy)*	Resolution Date *(dd/mm/yy)*
☐ Fever	_____/_____/_____	_____/_____/_____
☐ Rash	_____/_____/_____	_____/_____/_____
☐ Conjunctivitis	_____/_____/_____	_____/_____/_____
☐ Arthralgia (joint pain)	_____/_____/_____	_____/_____/_____
☐ Neurological symptoms (*specify)* _____	_____/_____/_____	_____/_____/_____

Other Symptoms (e.g., Headache, Myalgia, Eye pain, etc.):

Comments (*if applicable)*

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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