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: www.state.nj.us/health/cd/topics/zika.shtml.

Review CDC's Zika Travel Information page to determine if your patient traveled to an area experiencing Zika transmission: www.cdc.gov/zika/geo

Steps: 1) Fax the completed worksheet to the 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 ( ) -

Race
☐ White ☐ Black ☐ American Indian or Alaskan Native
☐ Asian ☐ Pacific Islander/Native Hawaiian ☐ Other____________

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Zika Exposure History (select all that apply)

Is the patient pregnant? ☐ No ☐ Yes **IF PREGNANT, estimated date of delivery (EDD):** _____ / _____/ _____

If pregnant, are there fetal abnormalities suggestive of Zika on ultrasound? ☐ Yes ☐ No ☐ Unknown/ ultrasound not done

Symptom Status ☐ Currently symptomatic ☐ Recovered /Formerly symptomatic ☐ Asymptomatic*

****Asymptomatic persons do not meet NJDOH testing criteria unless fetal/infant abnormalities are detected, there is ongoing travel exposure, in cases of fetal loss/infant death, or other extenuating circumstance***

☐ Travel to area with Zika ☐ Ongoing travel (at least weekly) to area with Zika	Travel location(s):	Travel dates:	From: ___/___/____ To: ___/___/___ From: ___/___/____ To: ___/___/___
☐ Unprotected sexual contact with Zika exposed partner	Date(s) 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: ___/___/____

List all signs and symptoms with onset/resolution dates:

	Onset Date *(mm/dd/yy)*	Resolution Date *(mm/dd/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 ________ ☐ Previous Zika diagnosis (*mm/yy)* ________________

☐ Dengue virus ________ ☐ Powassan virus ________ ☐ Other flavivirus/arboviral disease ________________

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 go to have their blood drawn)**