Zika Virus Patient Information Worksheet

CDRSS #:_____

Below is the clinical and exposure information the New Jersey Department of Health (NJDOH) needs to consider/approve a Zika virus test. Providers may choose to use this worksheet to assist in collecting their patient's history. Providers can call their LHD for approval, or fax this completed form to request approval. This is only intended to assist the process. Please check the following website for the latest NJDOH guidance on current criteria for testing: http://www.nj.gov/health/cd/zika/techinfo.shtml. Refer to the CDC's Zika Travel Information page to determine whether the country to which your patient traveled is 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) The LHD will review and complete the required laboratory test request form (SRD-1) with unique code that authorizes testing. Specimens without this approved form will be delayed or possibly rejected.
3) If approved, the LHD will fax SRD-1 form to your office along with instructions for having specimens collected.

Patient Name:	Patient DOB: Patient Sex:
Patient Address:	Patient Phone Number:
Travel location(s) with arrival and departure dates: **------->** *For pregnant, all travel during pregnancy and 8 weeks prior.* Locations must be on the list at: www.cdc.gov/zika/geo	Location From To
Other Exposure: □ Congenital □ Sexual □ Blood Transfusion □ Organ Recipient □ Other _____ Date(s) of exposure: _____	
Is patient pregnant? NO YES **------->**	**IF PREGNANT:** Estimated Date of Delivery: _____
If applicable, date of last ultrasound/any concerns:	
Symptom status: ____ Currently symptomatic → ____ Recovered /formerly symptomatic → ____ Asymptomatic →	Reports mosquito bites while traveling? YES NO

If ever SYMPTOMATIC, LIST SIGNS & SYMPTOMS with onset/duration dates:

S&S	Onset Date	Resolution Date	If applicable, Other S&S Comments
□ Fever			
□ Rash			
□ Conjunctivitis			
□ Arthralgia (joint pain)			

Underlying conditions/significant or unique co-morbidities or complications, or other information, if applicable:

Immunization history and year of immunization if possible: *(Traveler may recall having a yellow immunization card)*
□ None
___Yellow Fever Vaccine Year_____
___Japanese Encephalitis Vaccine Year_____
___Tickborne Encephalitis Vaccine Year_____

Previous history of flavivirus/arboviral disease: □ None
□ West Nile Virus Year: _____ □ Chikungunya Virus Year: _____ □ Other _____
□ Dengue Virus Year: _____ □ Powassan Virus Year: _____ Year: _____

Relevant flavivirus/arboviral tests/lab results:

Submitter Information (Doctor who is ordering Zika test)

Healthcare Provider Name:	**Patient ID Number:**
Institution Name	
Address:	
PHONE: FAX:	E-MAIL:
Point of Contact if not Provider	

Lab Information (Where the patient will be going for their blood draw, if known)

Institution Name

Note: This is not an official form of the NJDOH; its purpose is to assist providers in collecting the information necessary to get approval for testing for Zika virus. Any document with patient information should be stored in the patient's medical chart or shredded after use.