NJDOH ZIKA VIRUS PATIENT INFORMATION WORKSHEET

MR #: _____ **CDRSS #:** _____

INSTRUCTIONS

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: https://www.nj.gov/health/cd/topics/zika.shtml

Review CDC's Zika Travel Information page to determine if your patient traveled to an area at risk for Zika: 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.

Demographics

Patient Last Name **First Name**	**DOB:** ____ / ____ / ____	**Phone number**
Address	**City**	**Municipality**

Ethnicity
☐ Hispanic ☐ Unknown
☐ Non-Hispanic

Race
☐ White ☐ Black ☐ Asian ☐ Pacific Islander
☐ American Indian or Alaskan Native ☐ Unknown

Physician and Facility Information

Physician who is ordering the Zika virus test

Name: _____

Address: _____

Phone:_____ Fax: _____

Email: _____

Facility (if hospitalized)

Name of facility: _____

Date of admission: ___ /___ /_____

Date of discharge: ___ /___ /_____

Name of Lab *(where patient will go for specimen collection)*: _____

Clinical Status

Patient's symptom status: ○ Currently symptomatic ○ Previously symptomatic ○ Asymptomatic*

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

Sign/Symptom	Response	Onset	Resolution	Additional required information
Fever	○ Yes ○ No ○ Unk	___/___/_____	___/___/_____	Tmax:
Rash	○ Yes ○ No ○ Unk	___/___/_____	___/___/_____	
Conjunctivitis	○ Yes ○ No ○ Unk	___/___/_____	___/___/_____	
Arthralgia	○ Yes ○ No ○ Unk	___/___/_____	___/___/_____	
Neurological symptoms	○ Yes ○ No ○ Unk	___/___/_____	___/___/_____	Describe:

Additional symptoms (e.g., headache, myalgia, eye pain, etc.)**:**

Is patient pregnant? ○ Yes, Estimated Date of Delivery: _____ ○ No ○ Unk.

If pregnant, are there fetal abnormalities suggestive of Zika on ultrasound? ○ Yes ○ No ○ Unk./Ultrasound not preformed

Did the patient receive the following vaccinations? If yes, indicate the year of immunization if known.

☐ Yellow Fever Date: _____ ☐ Japanese Encephalitis Date: _____ ☐ Tickborne Encephalitis Date: _____

Previous history (year) of flavivirus/arboviral disease: ☐ West Nile Virus Year: _____ ☐ Previous Zika diagnosis (mm/yy): _____

☐ Chikungunya Year: _____ ☐ Dengue Year: _____ ☐ Powassan Year: _____ ☐ Other:_____ Year: _____

Was patient tested for Dengue? ○ Yes ○ No ○ Unk **Results:** _____

Risk factors

Did patient travel to an area with a risk of Zika?

○ Yes ○ No ○ Unk

Travel locations:_____

Date of arrival: _____ Date of departure: _____

Did patient have unprotected sexual contact with Zika exposed partner?

○ Yes ○ No ○ Unk

Date(s) of first and last unprotected sexual contact with Zika exposed partner: _____

Sexual partner's travel location(s): _____

Date of arrival: _____ Date of departure: _____

If patient had a different Zika virus exposure, specify: ☐ Congenital/Perinatal ☐ Laboratory/Healthcare ☐ Blood transfusion

☐ Organ recipient ☐ Other exposure, specify:_____

Additional Notes