

Zika Virus Testing Authorization Request

1. Completed form should be sent by fax to: Chicago Department of Public Health Communicable Disease program: **fax 312-746-4683**.
2. Submitting lab should include IDPH Arboviral Lab Submission Form with authorization number once provided by CDPH.

CDC provider resource link: <http://www.cdc.gov/zika/hc-providers/diagnostic.html>

Form Completed by Name: _____ Phone: _____ Email: _____

Patient FName: _____ LName: _____ Phone: _____

Address: _____ DOB: _____ Age: _____ Sex: M F

City: _____ State: _____ Zip: _____

Provider FName: _____ LName: _____ Facility: _____

Phone: _____ Email: _____

Does the patient have symptoms of Zika virus disease? Y N

Date of first symptom onset: _____; Symptoms (mark all that apply):

Rash If Yes, Maculopapular Petechial Purpuric Other: _____

Fever; Recorded Temp: _____ Joint pain Conjunctivitis Myalgia Other: _____

Specimen collected: Y N Specimen Collection Date: _____ Specimen Source(s): _____

Did the patient or patient's pregnant mother travel to an [area with known Zika virus transmission](#): Y N

Country visited: _____ City: _____ State: _____ Departure Date: _____ Return Date: _____

Country visited: _____ City: _____ State: _____ Departure Date: _____ Return Date: _____

Reason for Travel: Business Vacation Visit Family Mission Moved Other: _____

History of living in an area with risk for Zika transmission? Y N If Yes, area(s): _____ Approximate Dates: _____

History of frequent travel (e.g., daily or weekly) to an area with risk for Zika transmission? Y N If Yes, area(s): _____

History of living in a [dengue-endemic area](#)? Y N If Yes, countries: _____ Approximate Dates: _____

Prior Diagnosis of Chikungunya? Y N Date: _____ Prior Diagnosis of Dengue Fever? Y N Date: _____

History of receiving yellow fever or Japanese encephalitis vaccine? Y N Date: _____

Did the patient or patient's pregnant mother have unprotected sexual intercourse with an individual who traveled to an area with known Zika virus transmission? Y N Most recent date of unprotected sex: _____

Country visited: _____ City: _____ State: _____ Departure Date: _____ Return Date: _____

Did the sexual partner have symptoms consistent with Zika virus: Y N Symptoms: _____

Was the sexual partner tested for Zika virus: Y N Results: _____

Is the patient pregnant? Yes No

If Yes,

a. Approximate gestational age at time of potential exposure: _____ (week)

b. If applicable, approximate gestational age at time of symptom onset: _____ (week)

c. Approximate date of conception: _____ and gestational age at present: _____ (week)

d. Date of last ultrasound: _____ If, not performed, date scheduled: _____

e. Ultrasound findings: Normal Brain Calcification Microcephaly IUGR Other: _____

Additional tests ordered (and results if available) for other etiologies: _____

Additional Comments: