



DCHHS Laboratory Test Request Form — Zika Virus PCR and Serology

- See **DCHHS Submission Instructions for Zika Virus Testing** at: www.dallascounty.org/department/hhs/epistats.html. DCHHS LRN lab can ONLY accept specimens from **residents** of the counties comprising its service area: **Collin, Dallas, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, Rains, Rockwall, and Van Zandt**
- For all non-Dallas County residents, submitter must obtain prior approval of the respective County/State health department, and **approval must accompany this form**
- Test results will be transmitted by fax to the listed submitter, or for non-Dallas residents to the respective County or State regional health department

***Required Fields—Omission of required information may result in inability to test. Completed form must accompany submitted specimens.**

TESTING CRITERIA MET	*Requesting healthcare providers MUST check ONE of the following categories					<i>DCHHS Epi Use Only</i>																																																
	<input type="checkbox"/> 1. Patient with 1 or more symptoms compatible with Zika infection (e.g., fever, rash, joint pain, or conjunctivitis) up to 4 weeks after: spending time in an area with Zika transmission (see www.cdc.gov/zika/geo/active-countries.html for current list), OR unprotected sex with a partner who spent time in such areas. <input type="checkbox"/> 2. Pregnant woman who spent time in areas with active Zika virus transmission (during pregnancy or up to 8 weeks prior to conception), within 9 months after returning from travel, OR had unprotected sex with a partner who spent time in such areas. <input type="checkbox"/> 3. Patient with symptoms of Guillain-Barré syndrome (GBS) after spending time in an area with Zika virus transmission. <input type="checkbox"/> 4. Infant born to a woman who had positive or inconclusive test results for Zika infection. <input type="checkbox"/> 5. Infant with microcephaly or intracranial calcifications born to a woman who spent time in an area with Zika virus transmission while pregnant OR had unprotected sex with a partner who spent time in an area with active Zika virus transmission. <input type="checkbox"/> 6. Patient with compatible illness who does not meet the above testing criteria, but for whom there may be concern for an alternate (e.g., transplant, transfusion, local vectorborne) mode of transmission. {N.B. Local vector-borne transmission can be considered in persons >5 years of age, without travel exposures, who present with ≥3 symptoms compatible with Zika disease.} Requestor must call the DCHHS Epidemiology division at (214) 819-2004 for approval for testing.					Testing criteria met? <input type="checkbox"/> Y <input type="checkbox"/> N PCR: Z D C IgM: Z D C QA initials: _____ Date Rec'd: _____ CASE CLASSIFICATION <input type="checkbox"/> Non-congenital Zika: Confirmed/ Probable/ Asympt <input type="checkbox"/> Congenital Zika: Confirmed/ Probable/ Asympt <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not a Case																																																
PATIENT	*Last name: _____ *First name: _____ Patient ID # / Medical record #: _____ *Date of birth (MM/DD/YYYY): _____ Age: _____ *Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female *Race/Ethnicity: _____ *Address: _____ *City: _____ *State: _____ *County: _____ ZIP: _____ *Phone #: _____ Alt. phone #: _____																																																					
	SUBMITTER	*Physician / Hospital / Clinic name: _____ *Contact name: _____ *Email: _____ *Phone: _____ *Fax #: _____ Pager #: _____ Address: _____ City: _____ State: _____ ZIP: _____																																																				
CLINICAL HISTORY		*Date symptom onset: _____ Symptoms resolved? <input type="checkbox"/> Yes <input type="checkbox"/> No *Symptoms (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Fever <input type="checkbox"/> Rash <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Joint pain <input type="checkbox"/> Guillain-Barré <input type="checkbox"/> Hematospermia <input type="checkbox"/> Other (list): _____ *Patient pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, *weeks gestation: _____ Est Date Delivery: _____ Fetal/infant anomalies: <input type="checkbox"/> None <input type="checkbox"/> Unk <input type="checkbox"/> Microcephaly <input type="checkbox"/> Intracranial calcifications					<table border="1"> <thead> <tr> <th>Past Arboviral Infection(s)</th> <th>Yes</th> <th>No</th> <th>Unk</th> <th>Date</th> </tr> </thead> <tbody> <tr><td>Yellow fever</td><td></td><td></td><td></td><td></td></tr> <tr><td>Japanese encephalitis</td><td></td><td></td><td></td><td></td></tr> <tr><td>Tick-borne encephalitis</td><td></td><td></td><td></td><td></td></tr> <tr><td>St. Louis encephalitis</td><td></td><td></td><td></td><td></td></tr> <tr><td>West Nile virus</td><td></td><td></td><td></td><td></td></tr> <tr><td>Dengue</td><td></td><td></td><td></td><td></td></tr> <tr><td>Chikungunya</td><td></td><td></td><td></td><td></td></tr> <tr><td>Other: (list below)</td><td></td><td></td><td></td><td></td></tr> </tbody> </table>				Past Arboviral Infection(s)	Yes	No	Unk	Date	Yellow fever					Japanese encephalitis					Tick-borne encephalitis					St. Louis encephalitis					West Nile virus					Dengue					Chikungunya					Other: (list below)			
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*Failure to provide travel history may result in an inability to test or a delay																																																						
TRAVEL/ EXPOSURE HISTORY	<ul style="list-style-type: none"> • Did patient spend time in an area with Zika transmission within 4 weeks prior to symptom onset? <input type="checkbox"/> N/A <input type="checkbox"/> Unk <input type="checkbox"/> No <input type="checkbox"/> Yes, countries/cities and dates of travel: _____ • If <u>pregnant and asymptomatic</u> OR if patient is an <u>infant</u>, is there maternal history of time spent in an area with Zika transmission? <input type="checkbox"/> N/A <input type="checkbox"/> Unk <input type="checkbox"/> No <input type="checkbox"/> Yes, countries/cities and dates of travel: _____ • Did the patient's sexual partner spend time in an area with active Zika transmission? <input type="checkbox"/> N/A <input type="checkbox"/> Unk <input type="checkbox"/> No <input type="checkbox"/> Yes, countries/cities and dates of travel: _____ Was partner symptomatic? <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Yes, date of illness onset: _____ • Is there any epidemiological link to a person with laboratory evidence of recent Zika? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ • Is patient a recipient of blood products, organ or tissue transplants within past 30 days? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ Notes: _____																																																					



*Patient name: _____ *DOB: _____

Please follow DCHHS Submission Instructions for Zika Virus Testing, accessible at: <http://www.dallascounty.org/department/hhs/epistats.html>

SPECIMEN 1	*Contact name for submitting lab: _____ *Lab Email: _____ *Lab Phone#: _____ *Lab Fax #: _____				
	*Date of Collection (MM/DD/YYYY): _____ *Time of collection: _____ *Time of centrifugation: _____				
	*Specimen Source: <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Semen <input type="checkbox"/> Saliva <input type="checkbox"/> CSF <input type="checkbox"/> Other: _____				
DCHHS LABORATORY RECEIPT (DO NOT write below)					
Date specimen received: _____ <input type="checkbox"/> Cold <input type="checkbox"/> Frozen <input type="checkbox"/> Room temperature <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory					
DCHHS / DSHS/ CDC / COMMERCIAL LABORATORY REPORTS (DO NOT write below)					
RESULTS	Test	Lab Name (DCHHS/DSHS/CDC)	Date Reported	Result (Pos/Eqv/Neg/Ttr/ND)	Comments/Interpretation
	Zika PCR				
	Zika IgM				
	Zika IgG				<i>(Note: Zika IgG testing not available for national use at this time.)</i>
	Zika PRNT				
	CHIKV PCR				
	CHIKV IgM				
	CHIKV IgG				
	CHIKV PRNT				
	Dengue PCR				
	Dengue IgM				
	Dengue IgG				
	Dengue PRNT				

SPECIMEN 2	*Date of Collection (MM/DD/YYYY): _____ *Time of collection: _____ *Time of centrifugation: _____				
	*Specimen Source: <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Semen <input type="checkbox"/> Saliva <input type="checkbox"/> CSF <input type="checkbox"/> Other: _____				
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	Zika PCR				
	Zika IgM				
	Zika IgG				<i>(Note: Zika IgG testing not available for national use at this time.)</i>
	Zika PRNT				
	CHIKV PCR				
	CHIKV IgM				
	CHIKV IgG				
	CHIKV PRNT				
	Dengue PCR				
	Dengue IgM				
	Dengue IgG				
	Dengue PRNT				