



ZIKA TEST REQUEST FORM



FAILURE TO COMPLETE ALL FIELDS WILL RESULT IN SPECIMEN REJECTION OR DELAYED TESTING
SUBMIT A SEPARATE TEST REQUEST FOR EACH SPECIMEN TYPE

Public Health Laboratories
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CA Certified PHL #335637
CLIA #05D1066369

For Zika virus testing eligibility:
www.publichealth.lacounty.gov/acd/Diseases/EpiForms/ZikaEligibility.pdf
For Zika virus testing and notification information:
www.publichealth.lacounty.gov/acd/Zika/Test.htm

PUBLIC HEALTH
LAB USE ONLY

SUBMITTER INFORMATION				Date Submitted	
Requesting Physician Name (Last, First)		Requesting Physician Phone		Requesting Physician Email	
Facility Name	Facility Address (Street)		City	State	Zip
Facility Phone Number	Secure Fax Number For Results Reporting		Contact Person For Specimen and Phone Number		

PATIENT INFORMATION					
Patient Name (Last, First, Middle Initial)			Date of Birth (mm/dd/yyyy)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Address (Street)		City		State	Zip
Patient Primary Telephone Number		Patient Alternate Phone Number		MRN/Patient ID	

LAB INFORMATION					
Specimen Source <input type="checkbox"/> Serum <input type="checkbox"/> Cord Blood <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Urine <input type="checkbox"/> Placenta <input type="checkbox"/> Other: _____			Specimen Collection Date/Time (hh:mm AM/PM) ____/____/____ : ____ AM/PM		Specimen Storage Condition <input type="checkbox"/> Refrigerated <input type="checkbox"/> Frozen (-20°C)

TEST(S) REQUESTED – Current Lab Testing Algorithms Available at <http://www.cdc.gov/zika/laboratories/lab-guidance.html>

Arbovirus serology panel (with reflex to confirmatory PRNT or rRT-PCR if required) for Zika, Chikungunya, Dengue, and West Nile Viruses

Arbovirus rRT-PCR (with reflex to serology or PRNT if required) for Zika, Chikungunya, and Dengue Viruses

Immunohistochemistry (fixed tissue or paraffin block)

Histopathology (fixed tissue or paraffin block)

PRNT for Zika/Chikungunya/Dengue/West Nile Virus Confirmation (Previous IgM serology positive result(s) required for PRNT)

CLINICAL INFORMATION

PREGNANCY STATUS

Yes: # Weeks Pregnant _____ OR Estimated Due Date: _____ Ultrasound Evidence of Microcephaly/Calcification

Not Pregnant Not Applicable

SYMPTOMS (CHECK ALL APPLICABLE)

Symptomatic: Fever Arthralgia Rash Conjunctivitis AND Symptom Onset Date: _____

Asymptomatic

Guillain-Barré Syndrome: Onset Date: _____

Other, Specify: _____

FLAVIVIRUS HISTORY (CHECK ALL PREVIOUS KNOWN VACCINATIONS AND ILLNESS) Flavivirus History Unknown

Tick-borne Encephalitis Yellow Fever Japanese Equine Encephalitis West Nile Virus Saint Louis Encephalitis Dengue

TRAVEL AND EXPOSURE HISTORY See current areas with Zika transmission at <http://www.cdc.gov/zika/geo/active-countries.html>

Did patient travel to an area with Zika transmission (including U.S with ongoing local Zika spread) within 14 days of symptom onset? Yes No Unknown

List all cities/countries/areas of travel: _____ Last Date of Travel: _____

Did patient's sexual partner travel to area with Zika transmission (including U.S. with ongoing local Zika spread)? Yes No Unknown

List all cities/countries/areas of travel: _____ Last Date of Travel: _____

Last Date of Unprotected Sexual Intercourse: _____ OR Unknown

Is the patient an infant with any of the following? Yes No

1) A mother with laboratory evidence of Zika virus infection Specify Mother's Name & Date of Birth: _____

2) Evidence of microcephaly/other birth defect: _____ AND A mom with recent travel to an area with Zika or had unprotected sex with traveler