

Chikungunya, Dengue, and Zika Testing Supplemental Information

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS. This information is REQUIRED prior to testing. This form should be included with the specimen(s) and DSHS laboratory submission form(s).

Submitter or Reporting Jurisdiction			
Person completing form: _____		Phone number: _____	
City: _____		County: _____	
Local or Regional Health Department representative contacted PRIOR to submitting specimen: Name: _____ Agency: _____			
Patient's Demographic Information <i>Use MM/DD/YYYY format for all dates</i>			
Last name: _____		Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
First name: _____		If YES , please provide <u>at least one</u> of the following:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Date of birth: ___/___/___		Estimated delivery date: ___/___/___	
Address: _____		OR date of last menstrual period: ___/___/___	
City: _____ Zipcode: _____		OR gestational age at illness onset: _____	
County of residence: _____		OR oldest gestational age in Zika-affected area: _____	
Patient's Illness Information <i>(Check all that apply; Use MM/DD/YYYY format for all dates)</i>			
Patient symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnancy, Fetal, and/or Neonatal Complications:	
If YES , illness onset date: ___/___/___		<input type="checkbox"/> Fetal loss Date: ___/___/___	
<input type="checkbox"/> Arthralgia <input type="checkbox"/> Guillain-Barré Syndrome		<input type="checkbox"/> Intracranial calcifications	
<input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Headache		<input type="checkbox"/> Microcephaly	
<input type="checkbox"/> Fever <input type="checkbox"/> Myalgia		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Rash <input type="checkbox"/> Nausea/vomiting		_____	
<input type="checkbox"/> Other _____		_____	
Patient's (or Mother's for Neonates) Travel History <i>Use MM/DD/YYYY format for all dates</i>			
Did the patient travel outside of residence county in 2 weeks prior to illness onset (or during pregnancy)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If YES , dates of travel: ___/___/___ to ___/___/___			
County(s), State(s), or Country(s)* visited: _____			
Sexual Partner's Travel History <i>Use MM/DD/YYYY format for all dates</i>			
Did the patient's sexual partner travel to an area of ongoing Zika virus transmission*? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A			
If YES , provide ALL of the following:			
Date of most recent sexual contact: ___/___/___			
Dates of travel: ___/___/___ to ___/___/___			
County(s), State(s), or Country(s)* visited: _____			
Other Epidemiologic Linkages <i>(Check all that apply)</i>			
<input type="checkbox"/> Household member or other close contact diagnosed with Zika or a Zika-like illness			
<input type="checkbox"/> Association in time and place with a person with laboratory evidence of Zika infection			
<input type="checkbox"/> Receipt of blood, blood products, or organ/tissue transplant within 30 days of symptom onset			
<input type="checkbox"/> Occupational/Laboratory exposure; location: _____			
Arboviral Testing Performed or Pending at Other Laboratories <i>(Complete all that apply)</i>			
<input type="checkbox"/> None		<input type="checkbox"/> Commercial lab: _____	
		<input type="checkbox"/> Public health lab: _____	
Zika Tests and Results:	Chikungunya Tests and Results	Dengue Tests and Results:	Other: _____
<input type="checkbox"/> PCR: _____	<input type="checkbox"/> PCR: _____	<input type="checkbox"/> PCR: _____	_____
<input type="checkbox"/> IgM: _____	<input type="checkbox"/> IgM: _____	<input type="checkbox"/> IgM: _____	_____

*See maps/lists of affected areas: www.cdc.gov/zika www.cdc.gov/dengue www.cdc.gov/chikungunya