Zika Virus Disease
Consultation Form for Testing Approval for Persons Age 14 and Older

Date form completed:_____/____/_____ (*For all dates, use format:* MM/DD/YYYY)

Patient Demographics and Contact Information

Patient name: Last _____ First _____ Middle_____

Date of birth: ____/____/_____ Age: _____ | Sex: ☐ Female ☐ Male | Does patient have a pregnant partner? ☐ Yes ☐ No

If female: Pregnant ☐ Yes ☐ No Expected Delivery Date: ____/____/_____ OR LMP: ____/____/_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Street Address: _____ Apt#_____

City: _____ State: _____ Zip:_____ County:_____

Phone number: (____)_____ Phone number (Alternate): (____)_____

Clinical information

Date of symptom onset ____/____/___ **OR** ☐ Asymptomatic

Fever ☐ Yes ☐ No Arthralgia/Myalgia ☐ Yes ☐ No Guillian-Barre Syndrome ☐ Yes ☐ No

Rash ☐ Yes ☐ No Conjunctivitis ☐ Yes ☐ No Neurologic manifestation ☐ Yes ☐ No

Complications of pregnancy including fetal loss, or fetus or neonate with congenital microcephaly or intracranial calcifications ☐ Yes ☐ No ☐ N/A If Yes: Date: ____/____/_____ Provide detail in Clinical Notes below

Other symptoms: _____

_____

Hospitalized ☐ Yes ☐ No ☐ Unknown If Yes: Admit date ____/____/_____

Reason:_____ Status: _____ Hospital Name:_____

Clinical Notes (*Note: Provide only additional detail that is relevant to testing approval*):

Exposure information prior to symptom onset (or specimen collection if asymptomatic)

1. Did the patient travel to or live outside their local area in the 14 days before onset of symptoms?
   ☐ Yes ☐ No If Yes: Travel start date:____/____/_____ Travel end date:____/____/_____
   If yes, Country(s) or City(s) and US State/Territory (include address(s) for domestic locations, if known):

   _____

   NOTE: (*International locations with active Zika transmission are listed here: http://www.cdc.gov/zika/geo/active-countries.html. US locations with travel advisories are listed here*: *http://www.cdc.gov/zika/geo/index.html*)

2. A) Did the patient have sexual contact [(vaginal sex (penis-to-vagina sex), anal sex (penis-to-anus sex), oral sex (mouth-to-penis sex or mouth-to-vagina sex), or the sharing of sex toys] without a barrier method to protect against infection) in the past 8 weeks? ☐ Yes ☐ No (If No: Go to Question 3)
   If Yes: Date of most recent occurrence: ____/____/_____ **Answer B, C and D:**
   B) Had any of the persons with whom the patient had sexual contact been diagnosed with Zika virus infection?
   ☐ Yes ☐ No ☐ Unknown

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C) Did any of the persons with whom the patient had sexual contact have symptoms of illness like fever, rash, joint pain, or red eyes? ☐ Yes ☐ No ☐ Unknown

D) Did any of the persons with whom the patient had sexual contact travel or *might* have traveled to a country, US state, or US territory with known local Zika transmission in the previous 6 months? ☐ Yes ☐ No ☐ Unknown

If Yes: List travel locations:_____

3. A) Did the patient receive a blood transfusion, organ or tissue transplant during 30 days prior to illness onset or testing? ☐ Yes ☐ No ☐ Unknown

   If Yes: Date of transfusion/transplant _____/____/_____ Hospital name_____

   B) Has the patient donated blood, tissue or organs in the past 30 days? ☐ Yes ☐ No ☐ Unknown

4. A) Did the patient work with Zika/flavivirus agents in a laboratory? ☐ Yes ☐ No ☐ Unknown

   If Yes: Laboratory name_____ Most recent date: ____/____/_____

   Known laboratory exposure to Zika/flavivirus? ☐ Yes ☐ No If Yes: Date of exposure: ____/____/_____

   B) Did the patient have a known exposure to blood or bodily fluids? ☐ Yes ☐ No ☐ Unknown

   If Yes: Date of most recent exposure: ____/____/_____

   Describe exposure:_____

5. Did the patient share needles with another person? ☐ Yes ☐ No ☐ Unknown

   If Yes: Most recent date: ____/____/_____

6. Did the patient provide materials from the Alabama Department of Public Health indicating that they should be tested for Zika (e.g., *letter, flyer or door hanger indicating that Zika activity was present in their area*)? ☐ Yes ☐ No

7. If **NONE** of the exposure questions (Q1-6) are "Yes": Is there additional clinical information (*e.g., 2 or more symptoms with no alternate diagnosis*) that you wish to be considered for testing approval? ☐ Yes ☐ No ☐ Not applicable

   If Yes, describe: (*Note: an ADPH physician may contact you to review the information provided, so provide as much detail as possible and include on-call contact information to ensure that additional discussion or requested information may be obtained as soon as possible to expedite testing approval and/or recommendations*)

Provider Information (NOTE: the facility contact should be the individual, phone number and email that will provide the most rapid follow up should specimen collection and/or additional information be required for testing approval)

Provider Name:_____ Degree(s):_____

Facility Name:_____

Facility Contact Name:_____

Facility Contact Phone Number: (____)_____ Facility Contact email:_____

Complete form and fax to (334) 206-3734 or email to ZIKATest@adph.state.al.us

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