Zika Virus Disease
Consultation Form for Testing Approval for Infants and Children Under Age 14

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

Patient Demographics and Contact Information

Patient last name: _____ Patient first name: _____Patient middle name: _____

Date of birth: ____/____/_____ | Age: _____☐ Days ☐ Months ☐ Years | Sex: ☐ Female ☐ Male

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

Other symptoms: _____

_____

Hospitalized ☐ Yes ☐ No ☐ Unknown

If Yes: 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:____/____/_____

   Country(s) or City(s) and US State/Territory:

   _____

   NOTE: (*International locations with active Zika transmission are listed here: http://www.cdc.gov/zika/geo/active-countries.html. For US locations, include City(s) and State/Territory*)

2. Did patient's mother travel to or live outside their local area during pregnancy or within two weeks of delivery?

   ☐ Yes ☐ No ☐ Not applicable

   If Yes: Travel start date:____/____/_____ Travel end date:____/____/_____

   If yes, Country(s) or City(s) and US State/Territory:

   _____

   NOTE: (*International locations with active Zika transmission are listed here: http://www.cdc.gov/zika/geo/active-countries.html. For US locations, include City(s) and State/Territory*)

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3. Did the patient's mother test positive for Zika? ☐ Yes ☐ No If Yes: Date of positive test :____/____/_____

4. Did the patient have microcephaly or intracranial calcifications detected prenatally or at birth? ☐ Yes ☐ No

5. Did the patient receive a blood transfusion, organ or tissue transplant during 28 days prior to illness onset or testing? ☐ Yes ☐ No ☐ Unknown

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

6. Did the patient provide materials from the Alabama Department of Public Health that indicated 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*)

Additional laboratory testing, if performed

Influenza: ☐ Yes ☐ No Result:_____ CBC: ☐ Yes ☐ No WBC:_____

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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