Health, Housing & Community Services Department
Public Health Division
1947 Center Street, 2nd floor
Berkeley, CA 94704
(510) 981-530 Fax 981-5345

Janet Berreman, MD, MPH
Health Officer

ZIKA VIRUS DISEASE TESTING REQUEST (EFFECTIVE 09/07/16)

Fax completely filled out form to 510-981-5345

ATTENTION: Requests for testing on specimens obtained from **Berkeley Residents** that are sent directly to Alameda County, California Department of Public Health, or the Centers for Disease Control & Prevention laboratories **will not be tested** unless this form is completed, and approval has been granted by the City of Berkeley Public Health Division.

Please complete this form, fax to (510) 981-5345 and call (510) 981-5300. For after-hours specimen collection and shipment instructions, call (510) 981-5911.

NOTE: Testing for Alameda County residents must be approved by the Alameda County Public Health Department Acute Communicable Disease Unit at (510) 267-3250.

REQUESTING PROVIDER *A secure email, working fax number and direct phone line are required

Date of request:
Name/Title:
Direct Phone (not call center)**:**
Alternate phone:
Name of person completing form (if not provider):
Phone (if different from above):

Facility Name:
Facility Address:
Fax:
Email:
Email:

PATIENT DEMOGRAPHICS

Name:
DOB: Age:
Sex: ☐F ☐M
Email:

Address:
City:
Zip Code:
Phone:
Cell:

CLINICAL INFORMATION *Incomplete clinical information will lead to delay or denial of testing approval

Symptoms:	☐Yes ☐No	If yes, first onset date:	Duration:	to
Fever:	☐Yes ☐No	If yes, date of onset:	Tmax:	F/C (if known)
Joint pain:	☐Yes ☐No	If yes, date of onset:		
Conjunctivitis:	☐Yes ☐No	If yes, date of onset:		
Maculopapular rash:	☐Yes ☐No	If yes, date of onset:		
Guillain-Barre Syndrome:	☐Yes ☐No	If yes, date of onset:		

Pregnant: ☐**Yes** ☐**No**

If pregnant, complete this box

EDD: Number of weeks gestation:
Initial dating U/S done: ☐Yes ☐No Date:
Formal U/S done: ☐Yes ☐No Date:
Other information:

Ultrasound Results:
Microcephaly: ☐Yes ☐No
Intracranial calcifications: ☐Yes ☐No
Other Abnormalities: : ☐Yes ☐No

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History of:

Dengue Fever: ☐Y ☐N If yes, date:
West Nile Virus: ☐Y ☐N If yes, date:
St. Louis Enceph: ☐Y ☐N If yes, date:

Received:

Yellow Fever vaccine: ☐Y ☐N If yes, date:
Jap. Enceph. vaccine: ☐Y ☐N If yes, date:

EPIDEMIOLOGICAL INFORMATION *Incomplete information will lead to delay or denial of testing

Traveled to or resides in an area with active Zika Virus transmission: ☐Yes ☐No
http://www.cdc.gov/zika/geo/active-countries.html

If yes above, complete this box				
Dates of travel/residence: From	To	Country	Regions/States/Cities	Mosquito Bites
				☐Y ☐N ☐Unk
				☐Y ☐N ☐Unk
				☐Y ☐N ☐Unk
				☐Y ☐N ☐Unk
				☐Y ☐N ☐Unk

Mosquito bites since returning to U.S.: ☐Yes ☐No ☐Unknown
If yes, locations (streets, cities, states):

Unprotected sexual contact (i.e., vaginal/anal intercourse or oral sex) **with any person who traveled to or resides in an area with active Zika Virus transmission: ☐Yes ☐No**

If yes above, complete this box
Earliest date:
Latest (most recent) date:

* Please advise any women who are pregnant or planning to become pregnant to use barrier protection during ALL sexual contact

Was sexual partner referred for Zika Testing: ☐Yes ☐No
If yes, where:

Sexual Partner's information
Location of travel/residence:
Dates of travel/residence: to
Symptoms of partner:
☐None ☐Fever ☐Joint pain
☐Conjunctivitis ☐Maculopapular rash
Onset of symptoms:
Duration of symptoms (days):

Sexual Partner's Demographics
Name:
DOB: Sex: ☐F ☐M
Address:
Phone: