



Health, Housing & Community Services Department
Public Health Division
 1947 Center Street, 2nd floor
 Berkeley, CA 94704
 (510) 981-5300 Fax 981-5345

Lisa B. Hernandez, 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: _____ Facility Name: _____
 Name/Title: _____ Facility Address: _____
Direct Phone (not call center): _____ **Fax:** _____
 Alternate phone: _____ **Email:** _____
 Name of person completing form (if not provider): _____
 Phone (if different from above): _____ Email: _____

PATIENT DEMOGRAPHICS

Name: _____ Address: _____
 City: _____
 DOB: _____ Age: _____ Zip Code: _____
 Sex: F M Phone: _____
 Email: _____ 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		Ultrasound Results:	
EDD:	Number of weeks gestation: _____	Microcephaly:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Initial dating U/S done: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Intracranial calcifications:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formal U/S done: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Other Abnormalities: :	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other information: _____			



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Janet Berreman, MD, MPH
 Health Officer

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:		Country	Regions/States/Cities	Mosquito Bites
From	To			
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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

<p>If yes above, complete this box</p> <p>Earliest date: Latest (most recent) date:</p> <p>* Please advise any women who are pregnant or planning to become pregnant to use barrier protection during ALL sexual contact</p> <p>Was sexual partner referred for Zika Testing: <input type="checkbox"/>Yes <input type="checkbox"/>No If yes, where:</p>	<p>Sexual Partner's information</p> <p>Location of travel/residence: Dates of travel/residence: _____ to _____ Symptoms of partner: <input type="checkbox"/>None <input type="checkbox"/>Fever <input type="checkbox"/>Joint pain <input type="checkbox"/>Conjunctivitis <input type="checkbox"/>Maculopapular rash Onset of symptoms: Duration of symptoms (days): _____</p> <p>Sexual Partner's Demographics</p> <p>Name: DOB: _____ Sex: <input type="checkbox"/>F <input type="checkbox"/>M Address: Phone: _____</p>
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