DALLAS COUNTY HEALTH AND HUMAN SERVICES

Lab ID #: _____

Case ID #: _____

DCHHS Laboratory Test Request Form — Zika Virus PCR and Serology

- See DCHHS Submission Instructions for Zika Virus Testing at: www.dallascounty.org/department/hhs/epistats.html. DCHHS LRN lab can ONLY accept specimens from residents of the counties comprising its service area: ***Collin, Dallas, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, Rains, Rockwall, and Van Zandt***
- For all non-Dallas County residents, submitter must obtain prior approval of the respective County/State health department, and approval must accompany this form
- Test results will be transmitted by fax to the listed submitter, or for non-Dallas residents to the respective County or State regional health department

Required Fields—Omission of required information may result in inability to test. Completed form must accompany submitted specimens.

TESTING CRITERIA MET

Requesting healthcare providers MUST check ONE of the following categories

☐ 1. Patient with 1 or more symptoms compatible with Zika infection (e.g., fever, rash, joint pain, or conjunctivitis) up to 4 weeks after: spending time in an area with Zika transmission *(see www.cdc.gov/zika/geo/active-countries.html for current list), OR* unprotected sex with a partner who spent time in such areas.

☐ 2. Pregnant woman who spent time in areas with active Zika virus transmission (during pregnancy or up to 8 weeks prior to conception), within 9 months after returning from travel, OR had unprotected sex with a partner who spent time in such areas.

☐ 3. Patient with symptoms of Guillain-Barré syndrome (GBS) after spending time in an area with Zika virus transmission.

☐ 4. Infant born to a woman who had positive or inconclusive test results for Zika infection.

☐ 5. Infant with microcephaly or intracranial calcifications born to a woman who spent time in an area with Zika virus transmission while pregnant OR had unprotected sex with a partner who spent time in an area with active Zika virus transmission.

☐ 6. Patient with compatible illness who does not meet the above testing criteria, but for whom there may be concern for an alternate (e.g., transplant, transfusion, local vectorborne) mode of transmission. {N.B. Local vector-borne transmission can be considered in persons >5 years of age, without travel exposures, who present with ≥3 symptoms compatible with Zika disease.}

Requestor must call the DCHHS Epidemiology division at (214) 819-2004 for approval for testing.

DCHHS Epi Use Only

Testing criteria met? ☐ Y ☐ N

PCR: Z D C

IgM: Z D C

QA initials: _____

Date Rec'd: _____

CASE CLASSIFICATION

☐ Non-congenital Zika: Confirmed/ Probable/ Asympt

☐ Congenital Zika: Confirmed/ Probable/ Asympt

☐ Other: _____

☐ Not a Case

PATIENT

*Last name: _____ *First name: _____ Patient ID # / Medical record #: _____

*Date of birth (MM/DD/YYYY): _____ Age: _____ *Sex: ☐ Male ☐ Female *Race/Ethnicity: _____

*Address: _____ *City: _____ *State: _____

*County: _____ ZIP: _____ *Phone #: _____ Alt. phone #: _____

SUBMITTER

*Physician / Hospital / Clinic name: _____ *Contact name: _____

*Email: _____ *Phone: _____ *Fax #: _____ Pager #: _____

Address: _____ City: _____ State: _____ ZIP: _____

CLINICAL HISTORY

*Date symptom onset: _____ Symptoms resolved? ☐Yes ☐No

*Symptoms *(check all that apply):* ☐None ☐Fever ☐Rash ☐Conjunctivitis ☐Joint pain ☐Guillain-Barré ☐Hematospermia ☐Other *(list)*: _____

*Patient pregnant? ☐No ☐Yes, *#weeks gestation: _____ Est Date Delivery: _____

Fetal/infant anomalies: ☐ None ☐ Unk ☐Microcephaly ☐Intracranial calcifications

Flavivirus Vaccination History	Yes	No	Unk	Date
Yellow fever vaccine				
Japanese encephalitis				
Tick-borne encephalitis				

Past Arboviral Infection(s)	Yes	No	Unk	Date
Yellow fever				
Japanese encephalitis				
Tick-borne encephalitis				
St. Louis encephalitis				
West Nile virus				
Dengue				
Chikungunya				
Other: *(list below)*				

TRAVEL/ EXPOSURE HISTORY

Failure to provide travel history may result in an inability to test or a delay

- *Did patient spend time in an area with Zika transmission within 4 weeks prior to symptom onset*? ☐N/A ☐Unk ☐No ☐Yes, **countries**/cities and **dates of travel**: _____
- *If pregnant and asymptomatic **OR** if patient is an infant, is there maternal history of time spent in an area with Zika transmission?* ☐N/A ☐Unk ☐No ☐Yes, **countries**/cities and **dates of travel**: _____
- *Did the patient's sexual partner spend time in an area with active Zika transmission?* ☐N/A ☐Unk ☐No ☐Yes, **countries**/cities and **dates of travel**: _____ *Was partner symptomatic?* ☐No ☐Unk ☐Yes, date of illness onset: _____
- *Is there any epidemiological link to a person with laboratory evidence of recent Zika*? ☐No ☐Yes: _____
- *Is patient a recipient of blood products, organ or tissue transplants within past 30 days?* ☐No ☐Yes: _____

Notes: _____

Fax completed form to DCHHS Epidemiology: (214) 819-1933

CLIA #: 45D0672012

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DCHHS Laboratory Test Request Form:
Zika Virus PCR and Serology

*Patient name: _____ *DOB: _____

Please follow DCHHS Submission Instructions for Zika Virus Testing, accessible at: http://www.dallascounty.org/department/hhs/epistats.html

SPECIMEN 1

*Contact name for submitting lab: _____ *Lab Email: _____ *Lab Phone#: _____ *Lab Fax #: _____

***Date of Collection (MM/DD/YYYY)**: _____ *Time of collection: _____ *Time of centrifugation: _____

***Specimen Source**: ☐Serum ☐Urine ☐Amniotic Fluid ☐Semen ☐Saliva ☐CSF ☐Other: _____

DCHHS LABORATORY RECEIPT *(DO NOT write below)*

Date specimen received: _____ ☐Cold ☐Frozen ☐Room temperature ☐Satisfactory ☐Unsatisfactory

DCHHS / DSHS/ CDC / COMMERCIAL LABORATORY REPORTS *(DO NOT write below)*

RESULTS

Test	Lab Name (DCHHS/DSHS/CDC)	Date Reported	Result (Pos/Eqv/Neg/Ttr/ND)	Comments/Interpretation
Zika PCR				
Zika IgM				
Zika IgG				*(Note: Zika IgG testing not available for national use at this time.)*
Zika PRNT				
CHIKV PCR				
CHIKV IgM				
CHIKV IgG				
CHIKV PRNT				
Dengue PCR				
Dengue IgM				
Dengue IgG				
Dengue PRNT				

SPECIMEN 2

***Date of Collection (MM/DD/YYYY)**: _____ *Time of collection: _____ *Time of centrifugation: _____

***Specimen Source**: ☐Serum ☐Urine ☐Amniotic Fluid ☐Semen ☐Saliva ☐CSF ☐Other: _____

DCHHS LABORATORY RECEIPT *(DO NOT write below)*

Date specimen received: _____ ☐Cold ☐Frozen ☐Room temperature ☐Satisfactory ☐Unsatisfactory

DCHHS / DSHS/ CDC / COMMERCIAL LABORATORY REPORTS *(DO NOT write below)*

RESULTS

Test	Lab Name (DCHHS/DSHS/CDC)	Date Reported	Result (Pos/Eqv/Neg/Ttr/ND)	Comments/Interpretation
Zika PCR				
Zika IgM				
Zika IgG				*(Note: Zika IgG testing not available for national use at this time.)*
Zika PRNT				
CHIKV PCR				
CHIKV IgM				
CHIKV IgG				
CHIKV PRNT				
Dengue PCR				
Dengue IgM				
Dengue IgG				
Dengue PRNT				