pennsylvania
DEPARTMENT OF HEALTH

Zika Virus Laboratory Submission Form

Approved by:

Public Health Official Name/Date

In order for testing to be considered, **ALL** fields must be completed.

Report Date:

Patient Information: Neonate

Last name:	First Name:		Mom's Name/DOB:
DOB: ____/____/____	Age:	Sex: Male ☐ Female ☐	¢ŜfŜLJK2ÿŜY
Street Address:	Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Pacific Islander ☐ Other:		Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
City:	State:	Zip:	County:
Specimen Source (serum/urine/other):	Collection Date:	Patient ID:	

Patient's Provider Information:

Name:			
Street Address:	City:	State:	Zip Code:
Telephone:	Fax:	Submitting Lab Name and Phone (if not provider):	

Reason for Testing and Travel History: All information must be completed or testing will **NOT** be performed

☐ Mother traveled to Zika-affected area ☐ Other:	☐ Mother is **symptomatic** and did not travel to Zika-affected area, but had sexual contact with a person who did travel to affected area.	☐ Mother is symptomatic and did not travel to Zika-affected area, but is a **household contact** of a person who did travel to affected area.
☐ Patient's sexual partner traveled to Zika-affected area. **Last date of unprotected sex:____/____/_____**	Partner was symptomatic? ☐ Yes ☐ No Partner had mosquito bite(s)? ☐ Yes ☐ No	Travel Country (or countries for mother / mother's partner):
Travel Dates (for mother/ mother's partner):	____/____/____ to ____/____/____	

Clinical Information: All information must be completed or testing will **NOT** be performed

Microcephaly	☐ Yes	☐ No	Gestational Age at Birth:					
Has patient experienced any symptoms?	☐ Yes	☐ No	Date of Onset: ____/____/____					
Fever (≥38°C or 100°F)	☐ Yes	☐ No	☐ Unknown		Arthralgia	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown		Rash	☐ Yes	☐ No	☐ Unknown
Mosquito Bite	☐ Yes	☐ No	☐ Unknown		Guillain-Barre syndrome	☐ Yes	☐ No	☐ Unknown
Other: (List)								
Cranial Ultrasound (Date: _____)	☐ Yes	☐ No	Outcome: ☐ Normal		☐ Abnormal _____			
Measurements at birth	Head Circumference: ___ cm/in (Percentile ___), Weight: ____ g (Percentile ___), Length: ____ cm/in (Percentile ___)							

For submissions for Philadelphia residents and from Philadelphia healthcare providers, call (215) 685-6742 **and** fax this form to (215) 238 6947 for testing approval. If needed, specimen transport to the Bureau of Laboratories can also be arranged.

For more information visit: https://hip.phila.gov/DiseaseControlGuidance/DiseasesConditions/Arboviruses/Zika