City of Long Beach Department of Health and Human Services

Communicable Disease Control Program

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Long Beach, California 90815
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Zika Test Request Form

TESTING LOCATION:

☐ Public Health Laboratory ☐ Patient referred to LBDHHS for testing ☐ Commercial Laboratory (specify): ☐ LabCorp ☐ Quest Diagnostics ☐ Other: _____

Patient Name (Last, First, Middle Initial):	Date of Birth (mm/dd/yyyy):	Age:	Sex: FEMALE

Race/Ethnicity:

☐ White ☐ African American ☐ Latino/Hispanic ☐ Asian/Pacific Islander ☐ Other_____

Patient Address (Street):	City: LONG BEACH	State: CA	Zip:

Home Phone Number:	Cell Phone Number:	Medical Record Number:

Pregnancy Information: Number of weeks pregnant:_____ Estimated Date of Delivery:_____

PROVIDER INFORMATION Date Submitted:

Requesting Physician's Name (Last, First):	Requesting Physician's Phone:	Requesting Physician's Email:

Facility Name:

Facility Address (Street):	City:	State:	Zip:

Facility Phone Number:	Fax Number:	Submitter Name:

TRAVEL INFORMATION Current areas with active Zika transmission: https://wwwnc.cdc.gov/travel/page/zika-information

Has the patient traveled to or lived in an area with ongoing Zika transmission during pregnancy or in the 8 weeks before becoming pregnant?

☐Yes ☐ No ☐ Unknown

Country of travel/residence (Country, State, City):	Dates of travel/residence (mm/dd/yyyy): From:_____ To:_____

Has the patient's sexual partner traveled to or lived in an area with ongoing Zika transmission? ☐ Yes ☐ No ☐ Unknown

Country of travel/residence (Country, State, City): ☐ Same as above	Dates of travel/residence (mm/dd/yyyy): ☐Same as above From:_____ To:_____
Last date of unprotected sexual intercourse:_____or ☐ Unknown	

Reason for Travel?

☐ Business ☐ Vacation ☐ Visiting family ☐ Permanent residence ☐ Other: _____

CLINICAL INFORMATION

Is the patient symptomatic? ☐ Yes ☐ No

If Yes:

Onset date: _____

- ☐ Fever (≥38° C)
- ☐ Maculopapular rash
- ☐ Arthralgia (Joint pain)
- ☐ Nonpurulent conjunctivitis (Red eyes)
- ☐ Other: _____

Is the patient's partner symptomatic? ☐ Yes ☐ No

If Yes:

Onset date: _____

- ☐ Fever (≥38° C)
- ☐ Maculopapular rash
- ☐ Arthralgia (Joint pain)
- ☐ Nonpurulent conjunctivitis (Red eyes)
- ☐ Other: _____

Was the patient previously tested for:

- ☐ Chikungunya
- ☐ Dengue
- ☐ Unknown

Vaccination History:

- ☐ Yellow Fever
- ☐ Japanese Equine Encephalitis
- ☐ Unknown