

ID EPI ZIKA VIRUS DISEASE SUPPLEMENTAL FORM

Patient: Last _____ First _____

Date of Birth: ____/____/____ Gender: Male Female

Race: White Black Asian Other: _____ Hispanic/Latino Yes No Language English Spanish Other

Street Address: _____

City: _____ Zip Code: _____

Parish: _____ Phone: _____

Ordering Provider: _____ Phone: _____

Fax: _____

Asymptomatic

Symptomatic: Onset Date _____

Check all Applicable Symptoms

Fever

Rash

Arthralgia

Conjunctivitis

Myalgia

Headache

Other: _____

Travel to Zika Affected Area

Area: _____

Travel dates: _____

Travel reason: _____

Sexual Partners with Travel to Affected Area

Area: _____

Travel dates: _____

Dates of last unprotected sex: _____

If Pregnant

Gestational Weeks: _____

Last Ultrasound Date: _____

Normal Abnormal Unknown

Previous Infections

Dengue Yes No Unknown

Chikungunya Yes No Unknown

West Nile Virus Yes No Unknown

Previous Vaccinations

Yellow Fever Yes No Unknown

Japanese Encephalitis Yes No Unknown

Tickborne Encephalitis Yes No Unknown

FOR ID EPI USE ONLY

Approved for Zika testing? Yes No

Epidemiologist: _____

Date: _____

PLEASE FAX THIS COMPLETED FORM TO (504) 568-8290 BEFORE SUBMITTING TO THE LAB. IF THERE ARE ANY ADDITIONAL QUESTIONS, PLEASE CONTACT ID EPI AT (800) 256-2748.