

Local Health Department Use

Testing Authorization #

Health Department Recommended Specimens to Collect: Serum Urine Other: _____

Zika Virus Disease Request for Testing

Please complete this form and fax to the McHenry County Department of Health (MCDH) Communicable Disease (CD) Program at 815-334-0191 to determine if the patient meets criteria for testing through Illinois Department of Public Health (IDPH) Chicago Laboratory. If the patient meets criteria for testing, MCDH will fax this form to your office with the authorization number located in the upper right box. **If you do not receive this form or a phone call by the next business day please call MCDH at 815-334-4500.**

Provider Name: _____

Provider Email _____

Provider Phone _____

Provider Fax _____

Medical Facility Name and Address _____

Demographic Information

Patient Name: _____ Patient Phone: _____

Patient Address _____

Date of Birth: _____ Age: _____ Gender: Male Female Race: _____ Ethnicity: _____

Travel History

Country Visited: _____ Departure Date: _____ Return Date: _____

Country Moved From: _____ How Long Did Patient Live There: _____ Date Arrived to USA: _____

Reason for Travel: Vacation Business Other: _____

Was Patient Bitten By Mosquitoes? Yes No Unknown

Reason for Testing

Asymptomatic pregnant woman who traveled (testing 2 to 12 weeks after return) Symptomatic non-pregnant person who traveled

Symptomatic pregnant woman who traveled (testing 2 to 12 weeks after return)

Other, Explain _____

Clinical Information (If Applicable)

Symptom Onset Date: _____

Fever: Yes No Subjective Fever Measured fever (Maximum temperature measured: _____ ° F)

Rash: Yes No Type: Maculopapular Petechial Purpuric Other: _____

Additional Clinical Symptoms: Arthralgia Conjunctivitis Headache Myalgia Guillain-barré Syndrome Other: _____

Obstetric Information (If Applicable)

Pregnant: Yes No If yes, Gestation at illness Onset (In Weeks) _____ Expected Delivery Date: _____ Based On: _____

Name of Anticipated Delivery Hospital: _____ Was Fetal Ultrasound done? Yes No Date done: _____

Finding of Ultrasound: Brain calcification Microcephaly Other, describe: _____

If not done, date scheduled: _____

Was patient planning on starting a family: Yes No Estimated Date of Conception: _____ LMP: _____

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Patient Name: _____

DOB: _____

Partner Information (If Applicable)

Did patient's sexual partner live in or travel to an area with evidence of Zika virus transmission? Yes No

If yes, Country visited: _____ Departure Date: _____ Return Date: _____

Last date patient had unprotected sex with sexual partner: _____ Sexual Partner's Name: _____

Gender of sexual partner: Male Female If female, is she pregnant? Yes No

Was sexual partner symptomatic? Yes No

If yes what symptoms were present? Fever Rash Arthralgia Conjunctivitis Guillain-barré Syndrome Other: _____

Was sexual partner tested for Zika? Yes No

If yes, what was the result and name of provider who tested sexual partner? _____

Vaccination Information

Received Yellow Fever Vaccine Yes No If YES Provide Date: _____

Received Japanese Encephalitis Vaccine Yes No If YES Provide Date: _____

Specimen Information

Specimen Type: Serum Urine Other, describe _____

Anticipated Collection Date: _____

Please provide the patient with the following CDC recommendations below

For people who have traveled to an area with Zika	
If you are pregnant	Pregnant women should not travel to areas with Zika. If you must travel to an area with Zika, talk to your healthcare provider
If your sexual partner is pregnant	Use condoms correctly, every time you have vaginal, anal or oral sex or do not have sex for the entire pregnancy . Sex includes the sharing of sex toys.
If you and your partner are planning a pregnancy	Women-Wait at least 8 weeks after symptoms start or last possible exposure. Men-Wait at least 6 months after symptoms start or last possible exposure

See the CDC website for updated guidance regarding Zika virus, sexual transmission, and last possible Zika exposure

<http://www.cdc.gov/zika/prevention/protect-yourself-during-sex.html>

Contact Information for MCDH:

Phone: 815-334-4500

Confidential Fax: 815-334-0191

