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| Utah Department of Health (UDOH) Information |
| UDOH Staff Name: Click here to enter text. Date form completed Click here to enter a date. |
| Reporting Provider |
| Provider Name: Click here to enter text. Practice Name: Click here to enter text.  Provider Phone: Click here to enter text. Provider Email: Click here to enter text.  Alternate Provider Name: Click here to enter text. Alternate Provider Phone: Click here to enter text. |
| **Patient Demographic Information (Female)** |
| State of residence: Choose an item. State case ID number: Click here to enter text.  Last name: Click here to enter text. First name: Click here to enter text.  DOB: Click here to enter a date. Age: Enter age. Years Months Days  Race: White Black/African American American Indian Asian Alaskan Native Native Hawaiian/Pacific Islander  Ethnicity: Hispanic or Latino Not Hispanic or Latino  Pt Address: Click here to enter text.  Phone Number: Click here to enter text. Email: Click here to enter text. |
| Patient Travel History |
| Travel start date: Enter date. Travel end date: Enter date. \*Area(s) visited: Click here to enter text.  \**Area refers to country, state, or territory with active Zika virus transmission*  Does patient have known mosquito exposure? Yes No Unknown Date of Exposure: Click here to enter a date.  Unprotected sexual contact with male who has traveled outside country? Yes No  *If yes, see Transmission Modes of Interest to Patient- Unprotected sexual contact, partner exposed* |
| Patient Vaccination History |
| Previous vaccinations: Yellow Fever  Japanese Encephalitis  Tick-borne Encephalitis |
| Pregnancy Information |
| Currently pregnant: Yes No Unknown Expected delivery date: Click here to enter a date.  If yes, how far along (in weeks)? Enter # weeks. Most recent ultrasound date: Enter date. Unknown  Microcephaly: Yes No Suspect Fetal loss: Yes No  Planned hospital delivery? Yes No Unknown Name of hospital: Click here to enter text.  Pregnancy outcome? Live birth Stillborn (≥20 wks) Miscarriage (≥20 wks) Termination Unknown |
| Transmission Modes of Interest to Patient |
| Local vector-borne Organ/tissue transplant Blood/blood product transfusion Breastfeeding  Unprotected sexual contact with partner exposed to Zika\* Other: Click here to enter text.  \**Fill out partner information on reverse side* |
| Patient Clinical Information |
| Asymptomatic Symptomatic (Illness onset date: Click here to enter a date.) |
| Fever Yes No If yes: Subjective Measured (Max measured temperature: Enter temp.)  Rash Yes No If yes: Type: Maculopapular Petechial Purpuric Other  Guillain-Barre syndrome/acute flaccid paralysis: Yes No Suspect  Distribution Click here to enter text. Pruritic: Yes No  Arthralgia Yes No Myalgia Yes No Oral ulcers Yes No  Conjunctivitis Yes No Vomiting Yes No Headache Yes No  Diarrhea Yes No Peripheral edema Yes No  Hospitalized Yes No Died Yes No |
| Specimen Information |  |
| Specimen 1 collected: Enter date. Type: Serum CSF Urine Amniotic fluid  Saliva Placenta Other tissues |  | Type: □ Serum □ CSF □ Urine □ Amniotic fluid  □ Saliva □ Urine □ Placenta □ Other tissues |
| Specimen 2 collected: Enter date. Type: Serum CSF Urine Amniotic fluid  Saliva Placenta Other tissues |  | Type: □ Serum □ CSF □ Urine □ Amniotic fluid  □ Saliva □ Urine □ Placenta □ Other tissues |

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| Utah Department of Health (UDOH) Information |
| UDOH Staff Name: Click here to enter text. Date form completed: Click here to enter a date. |
| Reporting Provider |
| Provider Name: Click here to enter text. Practice Name: Click here to enter text.  Provider Phone: Click here to enter text. Provider Email: Click here to enter text.  Alternate Provider Name: Click here to enter text. Alternate Provider Phone: Click here to enter text. |
| **Patient Demographic Information (Male)** |
| State of residence: Choose an item. State case ID number: Click here to enter text.  Last name: Click here to enter text. First name: Click here to enter text.  DOB: Click here to enter a date. Age: Enter age. Years Months Days  Race: White Black/African American American Indian Asian Alaskan Native Native Hawaiian/Pacific Islander  Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown  Pt Address: Click here to enter text.  Phone Number: Click here to enter text. Email: Click here to enter text. |
| Patient Travel History |
| Travel start date: Enter date. Travel end date: Enter date. \*Area(s) visited: Click here to enter text.  \**Area refers to country, state, or territory with active Zika virus transmission*  Does patient have known mosquito exposure? Yes No Unknown Date of Exposure: Click here to enter a date. |
| Patient Vaccination History |
| Previous vaccinations: Yellow Fever Japanese Encephalitis Tick-borne Encephalitis |
| Special Interest in Patient History |
| Guillain-Barre syndrome/acute flaccid paralysis: Yes No Suspect |
| Transmission Modes of Interest to Patient |
| Local vector-borne Organ/tissue transplant Blood/blood product transfusion Other: Click here to enter text.  Unprotected sexual contact with female in last 6 mos\* Unprotected sexual contact with pregnant female in last  \* *Fill out partner information on reverse side* 6 mos\* |
| Patient Clinical Information |
| Asymptomatic Symptomatic (Illness onset date: Click here to enter a date.) |
| Fever Yes No If yes: Subjective Measured (Max measured temperature: Enter temp.)  Rash Yes No If yes: Type: Maculopapular Petechial Purpuric Other  Guillain-Barre syndrome/acute flaccid paralysis: Yes No Suspect  Distribution Click here to enter text. Pruritic: Yes No  Arthralgia Yes No Myalgia Yes No Oral ulcers Yes No  Conjunctivitis Yes No Vomiting Yes No Hematospermia (*for males*) Yes No Headache Yes No Diarrhea Yes No Peripheral edema Yes No  Hospitalized Yes No Died Yes No |
| Specimen Information |  |
| Specimen 1 collected: Enter date. Type: Serum CSF Urine Amniotic fluid  Saliva Placenta Other tissues |  | Type: □ Serum □ CSF □ Urine □ Amniotic fluid  □ Saliva □ Urine □ Placenta □ Other tissues |
| Specimen 2 collected: Enter date. Type: Serum CSF Urine Amniotic fluid  Saliva Placenta  Other tissues |  | Type: □ Serum □ CSF □ Urine □ Amniotic fluid  □ Saliva □ Urine □ Placenta □ Other tissues |

Testing Approval Guidance

**Immediately Approved**

Check Zika Virus Testing Approval Guide for testing approvals and recommendations

If approved, ensure provider has a Zika Test Request Form and will include it with the sample. Provider should write “EPI Approved” on bottom of test request form if patient is approved. Provide completed investigation form to Dallin, Gregg, or Jeff.

**Others**

Any others that do not meet the “Test” designation must be physician-requested and approved on a case by case basis by Dr. Nakashima. Provide completed investigation form to Dallin, Gregg, or Jeff and they will contact the physician after receiving a response from Dr. Nakashima.

**Specimen Determination**

If less than 7 days after symptom onset: PCR Test 0.5 mL of serum in a red top or in a serum separator tube (yellow or tiger top with gel) tubes (red or gold top with gel) tube. If less than 14 days after symptom onset: PCR test on urine in a sterile container **accompanied** with a serum sample. If greater than 14 days after symptom onset or patient is asymptomatic, then use PCR Test 0.5 mL of serum in a red top or in a serum separator tube (yellow or tiger top with gel) tubes (red or gold top with gel) tube.

**Specimen Collection**

3 mL of serum and/or 1.0 mL of CSF is required for serology testing. Blood is collected in red top or SST tube (yellow or tiger top with gel) tubes. CSF specimens are routinely tested undiluted and therefore require larger amounts. Whole blood is not acceptable for serology testing. Whenever possible, please transfer serum or CSF to a plastic tube with screw cap.

Specimens must include two (2) unique patient identifiers. Label all specimen containers with the following:

* Patient name.
* Patient ID number, DOB, Billing number, etc.
* Specimen type(s).
* Date collected.
* Initials of person collecting sample.

Identifying information can be provided by writing directly onto the vials in indelible ink.

If labels are used, they should be secured to insure retention during freezing.

Store and ship specimens with cold packs to keep the specimen at 4ºC.

Incomplete labels might be missing one of the following: patient name, patient date of birth, unique patient identifier, date and time of specimen collection, specimen type, and the name (or initials) of the person collecting the specimen. Incomplete or mislabeled specimens may be rejected for testing as preanalytic errors.

Specimens should be sent to:

UTAH PUBLIC HEALTH LABORATORY

4431 SOUTH 2700 WEST

TAYLORSVILLE, UTAH 84129

TELEPHONE: (801) 965-2400

FAX: (801) 965-2551

Utah Public Health Laboratory staff that work on Zika are:

Annette Atkinson ([aatkinson@utah.gov](mailto:aatkinson@utah.gov))

Kimberly Christensen ([kchrise@utah.gov](mailto:kchrise@utah.gov))

Bryan Burk ([bburk@utah.gov](mailto:bburk@utah.gov))