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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. [ ] UnknownMicrocephaly: [ ] Yes [ ] No [ ] Suspect Fetal loss: [ ] Yes [ ] NoPlanned 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 [ ] OtherGuillain-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 [ ] NoHospitalized [ ] 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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| **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 [ ] UnknownPt 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 [ ] OtherGuillain-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 [ ] NoHospitalized [ ] 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)

Kimberly Christensen (kchrise@utah.gov)

Bryan Burk (bburk@utah.gov)