TEXAS Department of State Health Services

Zoonosis Control Branch

Chikungunya, Dengue, and Zika Testing Supplemental Information

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS. This information is REQUIRED prior to testing. This form should be included with the specimen(s) and DSHS laboratory submission form(s).

Submitter or Reporting Jurisdiction

Person completing form:_____ Phone number:_____

City:_____ County:_____

Local or Regional Health Department representative contacted **PRIOR** to submitting specimen:

Name: _____ Agency: _____

Patient's Demographic Information *Use MM/DD/YYYY format for all dates*

Last name:_____

First name:_____

Sex: ☐ M ☐ F Date of birth: ___/____/_____

Address: _____

City: _____Zipcode: _____

County of residence: _____

Is patient pregnant? ☐ Yes ☐ No ☐ N/A

If **YES**, please provide at least one of the following:

Estimated delivery date: ____/____/_____

OR date of last menstrual period: ____/____/_____

OR gestational age at illness onset: _____

OR oldest gestational age in Zika-affected area: _____

Patient's Illness Information *(Check all that apply; Use MM/DD/YYYY format for all dates)*

Patient symptomatic? ☐ Yes ☐ No

If **YES**, illness onset date: _____/_____/_____

☐ Arthralgia ☐ Guillain-Barré Syndrome

☐ Conjunctivitis ☐ Headache

☐ Fever ☐ Myalgia

☐ Rash ☐ Nausea/vomiting

☐ Other_____

Pregnancy, Fetal, and/or Neonatal Complications:

☐ Fetal loss Date: _____/_____/_____

☐ Intracranial calcifications

☐ Microcephaly

☐ Other_____

_____

_____

Patient's (or Mother's for Neonates) Travel History *Use MM/DD/YYYY format for all dates*

Did the patient travel outside of residence county in 2 weeks prior to illness onset (or during pregnancy)?

☐ Yes ☐ No ☐ Unknown

If **YES**, dates of travel: _____/_____/_____ to _____/_____/_____

County(s), State(s), or Country(s)* visited:_____

Sexual Partner's Travel History *Use MM/DD/YYYY format for all dates*

Did the patient's sexual partner travel to an area of ongoing Zika virus transmission*?

☐ Yes ☐ No ☐ Unknown ☐ N/A

If **YES**, provide ALL of the following**:**

Date of most recent sexual contact: _____/_____/_____

Dates of travel: _____/_____/_____ to _____/_____/_____

County(s), State(s), or Country(s)* visited:_____

Other Epidemiologic Linkages *(Check all that apply)*

☐ Household member or other close contact diagnosed with Zika or a Zika-like illness

☐ Association in time and place with a person with laboratory evidence of Zika infection

☐ Receipt of blood, blood products, or organ/tissue transplant within 30 days of symptom onset

☐ Occupational/Laboratory exposure; location: _____

Arboviral Testing Performed or Pending at Other Laboratories *(Complete all that apply)*

☐ None ☐ Commercial lab: _____ ☐ Public health lab: _____

Zika Tests and Results:	**Chikungunya** Tests and Results	**Dengue** Tests and Results:	Other:_____
☐ PCR: _____	☐ PCR: _____	☐ PCR: _____	_____
☐ IgM: _____	☐ IgM: _____	☐ IgM: _____	

*See maps/lists of affected areas: www.cdc.gov/zika www.cdc.gov/dengue www.cdc.gov/chikungunya