Zika Virus Test Requisition

All fields must be completed for test to be processed. Each sample must be accompanied by a separate form

REQUIRED INFORMATION

For Lab Use Only

Specimen Type (Check only one)

□ Serum □ Amniotic fluid

□ CSF □ Other _____

□ Urine

Date of Collection _____________

Time of Collection _____AM / PM

Patient Information

MR# _____ ID#_____

Name _____

Address _____

City_____State ____Zip _____

Sex _____ Race ____ DOB____________

Epidemiological Information (Must have to test)

Does the patient have any of the following symptoms?

□ Yes □ No If yes, specify symptoms and onset date below

□ Fever □ Conjunctivitis

□ Maculopapular Rash □ Arthralgia

□ Other _____

Date of Symptom Onset:_____

Is the patient pregnant? □ Yes □ No If yes, estimated delivery date ____________

Did patient travel to/reside in area with active Zika transmission □ Yes □ No If yes,

Last Date of Travel:_____ List all cities/countries/areas of travel_____

Did patient's sexual partner travel to/reside in area with Zika transmission □ Yes □ No If yes,

List all cities/countries/areas of travel: _____ Last Date of Travel: _____

Last Date of Unprotected Sexual Intercourse: _____

Submitter Information:

Submitting Facility_____

Address _____

City_____State ____Zip _____

Contact Name:_____

Contact Phone:_____

Mississippi Public Health Laboratory
570 East Woodrow Wilson Drive
F.E."Ed" Thompson, Jr Building
Jackson, Mississippi 39216
Phone 601-576-7582

Zika Virus Test Requisition Instructions:

Purpose

This form is to provide submitters with a mechanism to request Zika Virus tests and to provide a template for information required for test result interpretation.

Instructions

1. The form is divided into 3 sections. The left third is for laboratory use only and should be left blank.
2. The right section is for patient information. Please attach label with patient demographic information or complete each line with applicable information. All written information must be legible.

MR # - Enter patient's medical records number. **ID #** - Enter patient's PIMS number if available.

• **Name** - Enter the patient's LAST NAME, FIRST NAME, AND MIDDLE INITIAL in sequence. The spelling of the name on the requisition and the specimen container/tube must be identical.

• **Address** - Enter the complete address where the patient currently lives. Post Office Box number should only be accepted if physical address is not available.

• **City** - Enter the name of the city in which the patient lives.

• **State** - Enter the state in which the patient lives.

• **Sex** - Enter "M" in space for male and "F" in space for female.

• **Race** - Enter the patient's race in the space provided (White, Asian, Black, Native American, Hawaiian/Pacific Islander, or other).

• **DOB** - Enter the Date of Birth (month, day, and year) of patient in the space provided.

• **Submitted by** - Enter the name of the clinic/submitter in the space provided. We will not be able to send a report unless submitter information is complete.

• **Address** – Enter the address of the clinic/submitter.

Contact information- Provide the name of the ordering physician including phone number.

3. The middle box is for clinical and sample information.

Specimen type- Check the appropriate box next to the type of specimen being submitted. Sometimes it is difficult for the lab to determine the origin of specimens by sight. The interpretation of this test is determined by the specimen type.

Date of Collection- Enter the date of specimen collection in MM/DD/YY format.

Time of Collection- Enter the time of specimen collection and select AM or PM

Required Epidemiological Information

Check all applicable patient symptoms. Date of onset, patient pregnancy status and exposure history **must** be filled in. Without this information, testing will **NOT** be performed. Exposure history can be obtained by simply asking the patient or a family member. "Don't know" or "unknown" are **NOT** acceptable responses.