



Zika Virus Testing Guidelines and Request Form for Healthcare Providers

Updated on 10/31/2017

To test a patient for Zika, please follow the process below:

Patient Criteria

San Joaquin County Public Health Services (SJCPHS) and California Department of Public Health (CDPH) can perform several different tests for Zika. In order to be tested, however, the patient must meet the following exposure AND clinical criteria:

1. Exposure (one of the following):

- Travel to an area with Zika virus transmission <http://www.cdc.gov/zika/geo>
- Unprotected sex with a partner who has traveled to an area with Zika virus transmission.

2. Clinical criteria (one of the following):

- Symptomatic individuals with onset of symptoms within the past 12 weeks.

To be considered symptomatic, the patient must have at least one of the following symptoms: fever, maculopapular rash, joint pain, or conjunctivitis.

- Asymptomatic pregnant women with possible Zika virus exposure within the past 12 weeks.
- Infants diagnosed with microcephaly.

Procedure

1. If the patient meets the above criteria, print the Zika Virus Testing Request Form and fax to SJCPHS at (209) 468-8222. **Failure to complete all fields will result in specimen rejection or delayed testing.**
2. Upon receipt of the request, SJCPHS will fax approval letter within one business day to inform you if the patient has been approved for testing.
3. After obtaining approval, please submit the specimens to the SJCPHS Laboratory (SJCPHL):
 - One red or gold top tube with 5-7 mL blood
 - 10-20 mL urine in a sterile container
 - Infants diagnosed with microcephaly will require consultation for appropriate specimens.

Samples must be stored at 4-8° C and immediately shipped on cold packs.

If you have difficulty obtaining or transporting the specimens to the lab, please call SJCPHS at (209) 468-3822.

4. The specimens will be tested for Zika virus at the SJCPHL or forwarded to CDPH, with an expected turnaround time of several weeks, depending on the need for confirmatory testing. You (the ordering provider) will receive lab results by fax.
5. Please notify the patient that SJCPHS may call to gather additional information.



Zika Virus Testing Request Form

Date: _____

PATIENT	Last Name: _____ First Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Race/Ethnicity: _____ County of Residence: _____ Patient Address: _____ <div style="text-align: right; margin-right: 100px;">City State Zip</div> Phone Number: _____ Cell Number: _____
SUBMIT BY	Physician / Hospital / Lab / Clinic name: _____ Contact Name: _____ Phone: _____ Fax: _____
CLINICAL	<input type="checkbox"/> Symptomatic: Date of Symptom Onset: _____ Symptoms (<i>Check all that apply; must have 1</i>): <input type="checkbox"/> Fever <input type="checkbox"/> Rash <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Arthralgia <input type="checkbox"/> Guillain-Barré Syndrome <input type="checkbox"/> Other: _____ Patient pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, # of weeks gestation currently: _____ OR; estimated delivery date: _____ <input type="checkbox"/> Asymptomatic pregnant woman: # of weeks gestation currently: _____ OR estimated delivery date: _____
EXPOSURE HISTORY	<input type="checkbox"/> Travel Exposure: Patient traveled to an area with Zika transmission within 14 days prior to symptom onset or within 12 weeks if asymptomatic? <input type="checkbox"/> No <input type="checkbox"/> Yes, countries and dates of travel: Departure Date: _____ Return Date: _____ Country: _____ <input type="checkbox"/> Sexual Exposure: Regardless of Travel History: Unprotected sex with sexual partner who traveled to an area with Zika virus transmission: <input type="checkbox"/> No <input type="checkbox"/> Yes, Date of last unprotected sex: _____ Countries of sexual partner travel: _____ Departure Date: _____ Return Date: _____
NOTES	
SPECIMEN (SJCPHS Only)	<u><i>For SJCPHS Use Only:</i></u> Approved for testing? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Specimen Collection: _____ Date Specimen Received: _____ Shipping date: _____ Specimen Source: <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> Other: _____

FAX, completed form to SJCPHS at 209-468-8222; Call SJCPHS at 209-468-3822 for questions.