



**City of Long Beach Department of Health and Human Services**  
**Epidemiology/Communicable Disease Control Program**

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 Long Beach, California 90815  
 Phone: (562) 570-4302 | Fax: (562) 570-4374



**ZIKA REPORT FORM: PREGNANT WOMAN**

**TESTING LOCATION:**

Public Health Laboratory  Patient referred to LBDHHS for testing  Commercial Laboratory (specify):  LabCorp  Quest Diagnostics  Other: \_\_\_\_\_

Patient Name (Last, First, Middle Initial):	Date of Birth (mm/dd/yyyy):	Age:	Sex: FEMALE
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Race/Ethnicity:  
 White  African American  Latino/Hispanic  Asian/Pacific Islander  Other \_\_\_\_\_

Patient Address (Street):	City: LONG BEACH	State: CA	Zip:
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Home Phone Number:	Cell Phone Number:	Medical Record Number:
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Pregnancy Information: Number of weeks pregnant: \_\_\_\_\_ Estimated Date of Delivery: \_\_\_\_\_

**PROVIDER INFORMATION** Date Submitted: \_\_\_\_\_

Requesting Physician's Name (Last, First):	Requesting Physician's Phone:	Requesting Physician's Email:
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Facility Name: \_\_\_\_\_

Facility Address (Street):	City:	State:	Zip:
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Facility Phone Number:	Fax Number:	Submitter Name:
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**TRAVEL INFORMATION** Current areas with active Zika transmission: <https://www.cdc.gov/zika/geo/active-countries.html>

Has the patient traveled to or lived in an area with ongoing Zika transmission during pregnancy or in the 8 weeks before becoming pregnant?  
 Yes  No  Unknown

Country of travel/residence (Country, State, City):	Dates of travel/residence (mm/dd/yyyy): From: _____ To: _____
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Has the patient's sexual partner traveled to or lived in an area with ongoing Zika transmission?  Yes  No  Unknown

Country of travel/residence (Country, State, City): <input type="checkbox"/> Same as above	Dates of travel/residence (mm/dd/yyyy): <input type="checkbox"/> Same as above From: _____ To: _____
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Last date of unprotected sexual intercourse: \_\_\_\_\_ or  Unknown

Reason for Travel?  
 Business  Vacation  Visiting family  Permanent residence  Other: \_\_\_\_\_

**CLINICAL INFORMATION**

Is the patient symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Onset date: _____ <input type="checkbox"/> Fever (≥38° C) <input type="checkbox"/> Maculopapular rash <input type="checkbox"/> Arthralgia (Joint pain) <input type="checkbox"/> Nonpurulent conjunctivitis (Red eyes) <input type="checkbox"/> Other: _____	Is the patient's partner symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Onset date: _____ <input type="checkbox"/> Fever (≥38° C) <input type="checkbox"/> Maculopapular rash <input type="checkbox"/> Arthralgia (Joint pain) <input type="checkbox"/> Nonpurulent conjunctivitis (Red eyes) <input type="checkbox"/> Other: _____	Was the patient previously tested for: <input type="checkbox"/> Chikungunya <input type="checkbox"/> Dengue <input type="checkbox"/> Unknown <hr/> Vaccination History: <input type="checkbox"/> Yellow Fever <input type="checkbox"/> Japanese Equine Encephalitis <input type="checkbox"/> Unknown
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