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

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ZIKA REPORT FORM: NON-PREGNANT

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: ☐ Male ☐ Female

Race/Ethnicity:
☐ White ☐ African American ☐ Latino/Hispanic ☐ Asian/Pacific Islander ☐ Other:____________

Patient Address (Street):	City: LONG BEACH	State: CA	Zip:

Home Phone Number:	Cell Phone Number:	Medical Record Number:

PROVIDER INFORMATION

Date Submitted:

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

Facility Name:

Facility Address (Street):	City:	State:	Zip:

Facility Phone Number:	Fax Number:	Submitter Name:

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 within the last 12 weeks? ☐ Yes ☐ No ☐ Unknown

Country of travel/residence (Country, State, City):	Dates of travel/residence (mm/dd/yyyy): From:____________ To:____________

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): ☐ Same as above Last date of unprotected sexual intercourse:____________ or ☐ Unknown	Dates of travel/residence (mm/dd/yyyy): ☐Same as above From:____________ To:____________

Reason for Travel?
☐ Business ☐ Vacation ☐ Visiting family ☐ Permanent residence ☐ Other: ____________

CLINICAL INFORMATION

Is the patient symptomatic? ☐ Yes ☐ No If Yes: Onset date:__________ ☐ Fever (≥38° C) ☐ Maculopapular rash ☐ Arthralgia (Joint pain) ☐ Nonpurulent conjunctivitis (Red eyes) ☐ Other: ____________	Is the patient's partner symptomatic? ☐ Yes ☐ No If Yes: Onset date:__________ ☐ Fever (≥38° C) ☐ Maculopapular rash ☐ Arthralgia (Joint pain) ☐ Nonpurulent conjunctivitis (Red eyes) ☐ Other: ____________	Was the patient previously tested for: ☐ Chikungunya ☐ Dengue ☐ Unknown Vaccination History: ☐ Yellow Fever ☐ Japanese Equine Encephalitis ☐ Unknown