Montana Zika Virus Infection Suspicion Checklist

Local Public Health Jurisdictions please complete this worksheet in consultation with the provider and submit to CDEPi if testing is requested.

Name of Patient:	**Phone:**	**DOB:**
Address:		
Provider name:	**Phone:**	**Gender:** Male Female
Clinic/Hospital Name:		

Reason for Zika Test Request

How was the Patient Exposed to Zika Virus?
(Please check the box in below section then complete details for that exposure.)

☐ **Travel to Zika impacted area(s)***

a. **Country or Specific Location of exposure:**
_____

b. **Travel Dates:**
___/____/____ **to** ___/____/____
Arrival **Departure**

☐ **Unprotected sex with an exposed partner**

a. **Country or Specific Location of exposure:**
_____

b. **Date(s) of sexual exposure:**
___/____/____ **to** ___/____/____

c. **With a** (circle) Male Female

d. **Did the partner have a positive Zika Test?**
(circle) Not tested Yes No

e. **Did the partner have symptoms of Zika infection?** (circle) No Yes

f. **If yes, when was the onset date?**
___/____/____

Patient's Clinical Presentation
(Please check the box for each symptom.
If yes, onset date is required.)

	No	Yes	Onset Date
Maculopapular Rash			
Acute onset of Fever			
Conjunctivitis			
Arthralgia			
Guillian-Barre			

If Pregnant, _____**Weeks** _____**Days**

Comments:

Clinical Disease and Vaccination History (Check box if yes.)

	Yellow Fever Disease	**Japanese Encephalitis**	**Dengue**
Diagnosed with disease	☐	☐	☐
Vaccinated against disease	☐	☐	☐

Would the provider like any information about Zika virus for you or your patients? If so, please describe.

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Name:	**Jurisdiction:**	**Phone:**
Source of Patient: (circle) Provider MT PHL Local Lab CDEpi Other		**Date:**

NOTE: ***Providers must report suspect cases to their local health department.*** LHJs are encouraged to contact the CDEpi 444-0273 to consult about the need for testing for individuals outside of the surveillance criteria.

*For a list of Zika-affected areas see: http://www.cdc.gov/zika/geo/index.html