PREMIER GENOMICS
INFECTIOUS DISEASE

ZIKA VIRUS SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	☐ Female ☐ Male
Street Address	City, State, Zip	Contact #

Patient Ethnicity ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Black ☐ Hispanic ☐ American Indian/ Native Alaskan ☐ Asian ☐ Other/Unknown

PATIENT HISTORY (please use separate page if necessary)	Allergies
Current Medications	

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

NPI #	Name (Last, First)	Facility Name
Street Address	City, State, Zip	
Phone	Fax	Email

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR TESTING

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order infectious disease testing OR is a representative of a licensed medical professional authorized to order infectious disease testing: acknowledges the patient has been supplied information regarding infectious disease testing and the patient has given consent for infectious disease testing to be performed. I request clinical interpretation of these results and confirm that this testing is medically necessary for the diagnosis or detection of a disease and that these will be used in the medical management and treatment decisions for this patient. Furthermore, the recipients information is true and correct to the best of my knowledge.

Medical Professional Signature Date

SPECIMEN INFORMATION

Patient samples will be tested by ELISA or RT-PCR based on CDC guidelines.

Date of Collection	Time of Collection	Time of Centrifugation	Specimen Source ☐ Urine and Serum	Storage Condition Prior to Shipping ☐ Refrigerated (4°C)

EPIDEMIOLOGY

VACCINATION HISTORY	YES	NO	UKN	DATE
Yellow Fever				
Japanese Encephalitis				
Tick-borne Encephalitis				

Is patient pregnant?
☐ NO ☐ YES, # weeks gestation (@ illness onset) __________
Date of last menstrual period ________________

Symptoms (check all that apply)
☐ Rash – R21 ☐ Vomiting – R11.10 ☐ Myalgia – M79.1
☐ Joint Pain – M25.50 ☐ Conjunctivitis – H10.9 ☐ Diarrhea – R19.7
☐ Headache – R51 ☐ Fever – R50.9; Temp:__________
☐ Other____

Date of Symptom Onset ________________________________

TRAVEL HISTORY

Did the patient travel to an area with Zika transmission* within 14 days prior to symptom onset? ☐ Unknown ☐ YES ☐ NO

If yes, list all countries/cities/dates of travel ________________________________

Does the patient's sexual partner have a history of illness consistent with Zika virus disease and a history of travel to an area with Zika transmission?
☐ Unknown ☐ YES ☐ NO

If yes, date of symptom onset ____________________ AND list all countries/cities/dates of travel ____________________

☐ Z11.59 - Encounter for screening for other viral diseases

** see cdc.gov/zika/geo/index.html for current list*

Patient acknowledgement for direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to lab rendering the test and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize this lab to be my Designated Representative for purposes of appealing any denial of benefits. I understand that I am financially responsible for any amounts not covered by my insurer for this test order. I also fully understand that I am legally responsible for sending the lab any money received from my health insurance company for performance of this genetic test. Further, I authorize the provider to release any pertinent medical records.

Patient or Legally Authorized Representative Date Patient E-mail