



New York City Department of Health and Mental Hygiene  
**PUBLIC HEALTH LABORATORY**  
*Jennifer Rakeman, Ph.D., Assistant Commissioner*  
 455 First Avenue New York, NY 10016  
 NYS CLEP PERMIT # : PFI 3849 CLIA #: 33D0679872

PHL USE ONLY

**LABORATORY TEST REQUEST-ZIKA OTHER**

Microbiology Section: Tel 212-447-6783 Fax 212-447-8258  
 Virology Section: Tel 212-447-2864 Fax 212-447-2877

• Is the patient a pregnant female who traveled to an area with known Zika transmission at any time during their pregnancy?  
 Yes No

• If not pregnant, is the patient a returning traveler with symptoms\* two weeks after their return from an area with known Zika transmission? Yes No

\*Symptoms include 2 or more of the following: acute onset of fever, maculopapular rash, arthralgia or conjunctivitis.

• Is this a patient with Guillian Barre Syndrome who traveled to an area with Zika transmission? Yes No

*If any of the answers to the above questions is YES, testing should be offered. If all of the answers are NO, testing is not warranted at this time.*

• Is the patient a neonate with microcephaly or intercranial calcifications born to a woman who traveled to an area with Zika virus transmission while pregnant? If yes, call Provider Access Line (1-866-692-3641) prior to forwarding specimens to NYC DOHMH.

- Failure to complete all fields may result in specimen being rejected.
- Spelling of patient name and DOB on form must exactly match that on specimen container.

**Patient Information**

LAST NAME*		FIRST NAME*		MIDDLE INITIAL	SUFFIX
DATE OF BIRTH* (MM/DD/YYYY)	GENDER* Male Female		Patient Pregnant? Yes No Unknown		
PATIENT ID NUMBER		PATIENT MEDICAL RECORD NUMBER*			
ADDRESS*		CITY*		STATE*	ZIP*
TELEPHONE		PHYSICIAN (if not submitter include contact info)			
Additional comments/Clinical syndrome/Exposure/Travel History				Date of onset of symptoms	

**SUBMITTER INFORMATION**

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY*			PROVIDER ID #		
PRIMARY CONTACT or PHYSICIAN	LAST NAME*		FIRST NAME*		
ADDRESS (including bldg. and room)*		CITY*		STATE*	ZIP*
TELEPHONE*	PAGER/CELL*	FAX	EMAIL		

**SPECIMEN INFORMATION**

Date of collection:	Time of collection:
<b>SPECIMEN</b>	<b>TEST REQUEST</b>
Umbilical Cord Blood Serum CSF Amniotic Fluid Frozen Tissue- Placental	<b>ZIKA RT-PCR</b>
Fixed Tissue-Placental *Requires additional CDC form	<b>ZIKA IHC</b>
DOHMH Bureau <b>BCD</b>	DOHMH contact: <b>Sally Slavinski</b>