

Michigan Zika Supplemental Questionnaire

**A COMPLETED copy of this form MUST ACCOMPANY SPECIMENS submitted to MDHHS Laboratories.
Specimens submitted with incomplete or missing forms WILL NOT BE TESTED**

Reason for Testing*: (must choose and complete one)

Pregnant woman exposed to Zika virus

Asymptomatic Symptomatic -- Illness onset date: _____

Estimated date of conception: _____

Route of exposure: Travel Dates of travel: _____

Affected place(s) visited:

Unprotected Sex Date of most recent exposure: _____

Symptomatic individuals exposed to Zika virus -- Illness onset date: _____

Must have at least one of the following: Fever Rash Arthralgia Conjunctivitis

Route of exposure: Travel Dates of travel: _____

Affected place(s) visited:

Unprotected Sex Date of most recent exposure: _____

****At this time, MDHHS is not performing testing for asymptomatic non-pregnant individuals or for the purposes of pre-conception planning/screening.***

Patient Information

Name: _____

Date of Birth: _____ Sex: female male

Street Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Previously vaccinated for Yellow Fever or Japanese Encephalitis: yes no

If yes, approximate date of vaccination: _____

Provider Information

Name: _____

Institution: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

Email address: _____

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