Indiana State
Department of Health

ISDH Zika Virus Testing Authorization Form

Please complete all fields of this form. All fields **MUST** be completed in order for testing to be authorized. Incomplete forms will result in a delay in authorization. Requests will be approved via **email**. Please ensure the “point of contact email address” provided on this form is correct.

Provider Information

Provider Name: ____

Facility Name and Address: _________________________________

____

____

Facility Phone Number: ____________________________________

Point of Contact Name: ____

Point of Contact email address: ____

Patient Information

Name (first and last): ____

Indiana county of residence: ____________________

Date of birth: ___/____/____ Sex: M F

Pregnant? Y N If yes, estimated date of delivery: ____/____/____

Symptoms? Y N If yes, date of symptom onset: ____/____/____

If yes, please indicate:

Fever Rash Arthralgia Conjunctivitis

Other: ____

Travel outside the United States? Y N

If yes, countries of travel: _____________________________________

Exact dates of travel: ____/____/____ to _____/____/_____

Upon completion of this form, **please fax to the ISDH at 317-234-2812**. An ISDH epidemiologist will follow-up with Zika virus testing authorization requests within 24 hours. For additional questions, please contact the ISDH Epidemiology Resource Center at 317-233-7125.