ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM. THE INFORMATION BELOW IS REQUIRED.
For manual orders only: Please fill out this form and submit it with the test request form.

PATIENT HISTORY FOR ZIKA VIRUS IGM ANTIBODY TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Physician: _____ **Physician Phone:** _____

Practice Specialty: _____ **Physician Fax:** _____

Clinical Diagnosis / Reason for Referral: _____

_____

ZIKA VIRUS IGM ANTIBODY CAPTURE (MAC) BY ELISA (ZIKA M) ELIGIBILITY

ARUP needs additional information to perform Zika Virus IgM Antibody Capture (MAC) by ELISA testing. Criteria set forth by the FDA for testing according to Emergency Use Authorization (EUA) requires that the following three questions be answered before testing can be performed. Please respond with a yes or no to these questions as they pertain to the patient's history.

1. **Is the patient pregnant?** ..... ☐ **Yes** ☐ **No**
2. **Has the patient been exposed to the Zika virus?** ..... ☐ **Yes** ☐ **No**
3. **Are the patient's symptoms consistent with the Zika virus?** ..... ☐ **Yes** ☐ **No**

If the required information cannot be provided electronically or faxed to Microbial Immunology at 801-584-5172, then please submit this patient history form with the sample. If you have any questions, contact ARUP Client Services at 800-242-2787 and reference key words *patient history form*.

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