

Department of Virology

Medical Research Institute

Colombo, Sri Lanka

Request form for Zika virus Testing

Lab use

Patient data

Patient Name

Age

Sex

Ward

BHT

Institution (complete name)

Travel history (specify the country and the date)

Flavivirus vaccination history (specify the vaccine with date) Eg: JE/YF

Address

Clinical history

Acute Fever (specify the date of onset)

Rash

Conjunctivitis

Myalgia /Arthralgia

Pregnancy (specify the PoA)

Co-morbid conditions (specify neurological problems)

Other

