



Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000

Governor Asa Hutchinson

Nathaniel Smith, MD, MPH, Director and State Health Officer

Zika Laboratory Instructions

Testing

If interested in testing for Zika Virus, *call us first*: 501-537-8969

- The Arkansas Department of Health (ADH) can now test for Dengue, Chikungunya, and Zika virus via PCR and Zika virus via IgM. Please call number above to determine test indicated.
- We can arrange additional testing via CDC which includes RT-PCR, Virus-Specific IgM Antibodies, or Plaque-Reduction Neutralization if needed
- Generally speaking, PCR tests will be done on persons with active disease or asymptomatic pregnant women within 14 days of disease onset/travel.
- IgM will be done on acute or convalescent disease when at least 4 days after onset/travel.
- PCR and IgM on all infants whose mother traveled to or resides in an area with Zika virus transmission during pregnancy

Specimens

- **Adult:** Please submit 3 SST (serum separator tubes) of serum. **Infant:** 1.5 ml of serum. Serum will need to be shipped cold or on ice to the ADH Lab.
- If patient has signs/symptoms within 14 days of return we can also perform PCR testing on urine. **Adult or infant:** Send 1 ml of urine in a sterile container. Specimen should be shipped cold.
- If outside the central Arkansas area, specimens can be taken to the local health unit in your county to be sent by courier to the ADH Lab. Please call the local health unit to let them know you need to use our courier.
- Providers please complete the Zika Request Form attached and send with specimen to the lab. Please fill out all demographics, pregnancy information, date of onset of symptoms, date of specimen collection, test requested, and mark appropriate testing requested.

Results

- Turnaround time for ADH tests will be within 2 business days for PCR and 3-4 business days for IgM results.
- Turnaround time for CDC testing is unpredictable given intense interest and testing volume nationally.

Resources

- For more information about Zika virus disease, please see the CDC Zika Virus website at <http://www.cdc.gov/zika>.

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- For questions, please call: 501-537-8969

Zika Request Form

ARKANSAS DEPARTMENT OF HEALTH
PUBLIC HEALTH LABORATORY
201 South Monroe
Little Rock, AR 72205

Patient Information (** Required fields)						Submitter Information (** Required fields)				
Patient's Last Name**		First Name**		Middle initial		Submitter ID or #**		Submitter's Name**		
Address**					ADC #	Submitter's Address**				
City**		State**	Zip**	Co. of Residence**			City**		State**	Zip**
DOB(mm/dd/yyyy)		Sex** <input type="radio"/> Male <input type="radio"/> Female	Race** <input type="radio"/> White <input type="radio"/> American Indian/Native Alaska <input type="radio"/> Native Hawaiian/Pacific Islander			<input type="radio"/> Black or American African		<input type="radio"/> Asian	<input type="radio"/> Other	
Ethnicity** <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Unknown		Phone		Contact		Fax				
Pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If Yes, Expected Date of Delivery?		MM	DD	YYYY				
Zika						Requestor Information (Required)				
<p style="text-align: center;">____ / ____ / ____ Date of Symptom Onset (mm/dd/yyyy)</p> <p style="text-align: center;">Test(s) Requested**</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Zika IgM ____ : ____ Time Collected** Specimen Type** <input type="radio"/> Serum <input type="radio"/> CSF </div> <div style="width: 45%;"> <input type="checkbox"/> Zika PCR ____ : ____ Time Collected** Specimen Type** <input type="radio"/> Serum Please Submit Second PCR Specimen Type <input type="radio"/> Urine <input type="radio"/> Amniotic Fluid <input type="radio"/> CSF </div> </div>						Requestor's Name**				
						(Required)				
						____ / ____ / ____ Date Collected**				
						PURPOSE (Select One)				
						<input type="radio"/> Family Planning <input type="radio"/> Diagnostic <input type="radio"/> Contact <input type="radio"/> Prenatal <input type="radio"/> Recheck specimen				
Notes: This form is for PRIVATE submitters only. <input type="radio"/> = Select only ONE; <input type="checkbox"/> = Check ALL that apply; ** = Required fields; For times, use Military format HH:MM										

REV. 09/07/2016

Onset of Symptoms	Test Type	Serum	Urine	Amniotic Fluid	CSF
Less than 4 days	PCR	Yes	Yes	No	No
4-14 days	PCR & IgM	Yes	Yes	Yes	Yes
Greater than 14 days	IgM	Yes	No	No	No