West Nile Virus (WNV) Infection Case Report

Fax this form to (415) 554-2848

To report by phone or for questions regarding testing or specimen submission, call the CD Control Unit, at (415) 554-2830 (24 hours/7 days a week).

See West Nile Virus Laboratory Testing Guidelines for clinical criteria for testing at the public health laboratory

Patient Information:

Last Name: _____ **First Name:**_____ **DOB:**___/___/___ **Age:**___ **Med Rec #:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Phone: Home (_____)_____ Work (_____)_____ **Occupation:** _____

Sex: ☐ Male ☐ Female ☐ Unknown **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Race:** ☐ White ☐ Black ☐ Unknown ☐ Asian/ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other: _____

Physician Information (Mandatory):

Name: _____ **Facility:** _____

Pager/Phone: (_____)_____ **Fax:** (_____)_____ **Email:** _____

Date of first symptom(s):___/___/___ ☐ Hospitalized **or** ☐ ER / Outpatient

If hospitalized, admit date: ___/___/___ **Discharge date:** ___/___/___ **If patient died, date of death:** ___/___/___

Clinical syndrome (check all that apply):

Encephalitis ……	☐ Yes	☐ No	☐ Unk
Aseptic meningitis ……	☐ Yes	☐ No	☐ Unk
Acute flaccid paralysis ….	☐ Yes	☐ No	☐ Unk
Febrile illness ……	☐ Yes	☐ No	☐ Unk
Asymptomatic ……	☐ Yes	☐ No	☐ Unk

Other _____

Do the following apply anytime during current illness:

In ICU ……	☐ Yes	☐ No	☐ Unk
Seizures ……	☐ Yes	☐ No	☐ Unk
Altered consciousness ….	☐ Yes	☐ No	☐ Unk
Fever ≥38˚C ……	☐ Yes	☐ No	☐ Unk
Headache……	☐ Yes	☐ No	☐ Unk
Rash ……	☐ Yes	☐ No	☐ Unk
Stiff neck……	☐ Yes	☐ No	☐ Unk
Muscle pain ……	☐ Yes	☐ No	☐ Unk
Paresis or paralysis ……	☐ Yes	☐ No	☐ Unk
Joint pain or arthritis ……	☐ Yes	☐ No	☐ Unk
Nausea or vomiting ……..	☐ Yes	☐ No	☐ Unk
Diarrhea ……	☐ Yes	☐ No	☐ Unk

Other: _____

CSF Results	CBC Results
Date: ____/____/____	Date: ____/____/____
RBC: ____	WBC: ____
WBC: ____	%Diff: _____
%Diff: _____	HCT: ____
Protein: ____	Plt: ____
Glucose: ____	

Other lab results (MRI/CT, etc.): _____

_____

_____

Travel/exposures <u>within 4 wks of onset</u> (specify details):

Mosquito bites/exposure ……	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Travel outside of California ……	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Travel outside the U.S. ……	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Donated blood ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Donated organ ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Received blood transfusion ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Received organ transplant ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Currently pregnant ……	☐ Yes	☐ No	☐ Unk
Week of gestation: ____			
Ever traveled outside the U.S. ……	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Ever rec'd yellow fever vaccine……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			

Past medical history:

Immunocompromised……	☐ Yes	☐ No	☐ Unk
Specify:_____			
Hypertension……	☐ Yes	☐ No	☐ Unk
Diabetes Type ____ ……	☐ Yes	☐ No	☐ Unk

Other significant history/exposures: _____

_____

_____

West Nile Virus Test Results:

Testing Laboratory	Specimen Type	Collection Date	Test Type	Result
_____	_____	___/___/___	_____	_____
_____	_____	___/___/___	_____	_____

Revised (09/2012)