

West Nile Virus (WNV) Infection Case Report

Date Form Completed: ___/___/___

Patient Information:

Last Name: _____ **First Name:** _____ **DOB:** ___/___/___ **Age:** ___ **Med Rec #:** _____
Address: _____ **City:** _____ **Zip Code:** _____
Phone: Home (_____) _____ **Work** (_____) _____ **Occupation:** _____
Sex: Male **Ethnicity:** Hispanic **Race:** White Asian/ Pacific Islander
 Female Non-Hispanic Black American Indian/Alaskan Native
 Unknown Unknown Unknown 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
 Muscle weakness Yes No Unk
 Other: _____

Past medical history:

Immunocompromised: Yes No Unk
 Specify: _____
 Hypertension Yes No Unk
 Diabetes Type _____ Yes No Unk
 Other: _____

CSF Results	CBC Results
Date: ___/___/___	Date: ___/___/___
RBC: _____	WBC: _____
WBC: _____	%Diff: _____
%Diff: _____	HCT: _____
Protein: _____	Pt: _____
Glucose: _____	

Travel/Exposures within 4 wks of onset (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: ___/___/___

Knowledge of WNV prior to illness:

Did patient do anything to avoid mosquito bites?
If yes, Yes No Unk
 - used insect repellent? Yes No Unk
 - drained standing water near home? Yes No Unk

Other significant history/exposures: _____

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

West Nile Virus Test Results:				
Testing Laboratory	Specimen Type	Coll Date	Test Type	Result

FAX this form to Disease Control at: (951) 358-5102 or (951) 358-5446
 For questions regarding testing or specimens, call DOPH laboratory at (951) 358-5070