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 ☐ 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	Coll Date	Test Type	Result
______________	____________	___/___/___	________	__________
______________	____________	___/___/___	________	__________

FAX this form: (510) 620-5896 or MAIL to: CDPH/CDER–West Nile Virus, 850 Marina Bay Parkway, Richmond CA 94804