

West Nile Virus (WNV) Infection Case Report

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:

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
 Fever ≥38°C..... Yes No Unk
 Headache Yes No Unk
 Rash Yes No Unk
 Stiff neck Yes No Unk
 Muscle pain/weakness Yes No Unk
 Altered consciousness Yes No Unk
 Seizures Yes No Unk

| CSF Results | CBC Results |
|-------------------|-------------------|
| Date: ___/___/___ | Date: ___/___/___ |
| RBC: _____ | WBC: _____ |
| WBC: _____ | %Diff: _____ |
| %Diff: _____ | HCT: _____ |
| Protein: _____ | Plt: _____ |
| Glucose: _____ | |

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

Past medical history:

Hypertension: Yes No Unk
 Diabetes Type _____ Yes No Unk

Other: _____

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: (707) 565-7839 or send with specimens to:

Questions regarding testing or specimens? Call (707) 565-4711.

**Specimen Receiving
 Public Health Laboratory
 3313 Chanate Road
 Santa Rosa, CA 95404**