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:

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 **<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: ___/___/___			

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: (510) 412-6263
or MAIL to: CDPH/Vector Borne Disease Section, 850 Marina Bay Parkway, Richmond CA 94804