

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
- 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: (415) 473-6002 Marin County HHS Communicable Disease Unit
 For questions regarding testing or specimens, call the Marin County HHS Communicable Disease Unit (415) 473-7805 or (415) 473-2623