

WEST NILE VIRUS SPECIMEN SUBMITTAL FORM – PLEASE USE ONE FORM PER PATIENT

West Nile virus testing is recommended on individuals with the following:

- A. Encephalitis
- B. Aseptic meningitis (Note: Consider enterovirus for individuals ≤ 18 years of age)
- C. Acute flaccid paralysis; atypical Guillain-Barré Syndrome; transverse myelitis; or
- D. Febrile illness compatible with West Nile fever\* and lasting ≥ 7 days (must be seen by health care provider):

\* The West Nile fever syndrome can be variable and often includes headache and fever ( $T \geq 38C$ ). Other symptoms include rash, swollen lymph nodes, eye pain, nausea or vomiting. After initial symptoms, the patient may experience several days of fatigue and lethargy.

**INSTRUCTIONS FOR SENDING SPECIMENS**

1. **Required specimens:**

- Acute Serum:** ≥ 2cc serum
- Cerebrospinal Fluid (CSF):** 1-2cc CSF if lumbar puncture is performed

2. If West Nile virus is highly suspected and acute serum is negative or inconclusive:

- 2<sup>nd</sup> Serum:** ≥ 2 cc serum collected 3-5 days after acute serum

- Refrigerated specimens should be sent on **cold pack** using an overnight courier
- If CSF is frozen, send on dry ice (all specimens may be sent on dry ice)
- Each specimen should be labeled with **date of collection**, **specimen type**, and **patient name**
- Please do not send specimens on Fridays.
- Send specimens to: **Marin County Public Health Lab, 920 Grand Avenue, San Rafael, CA 94901** **Hours: M-F, 8:00am to 12:00 noon and 1:00 to 5:00pm**

**\*\* IMPORTANT: THE INFORMATION BELOW MUST BE COMPLETED AND SUBMITTED WITH SPECIMENS \*\***

<b>Patient's last name, first name:</b>			<b>Patient Information</b>	
			Address _____	
			City _____ Zip _____ County _____	
Age or DOB:	Sex (circle): M F	Onset Date:	Phone Number (_____) _____	
<b>Clinical findings:</b> <input type="radio"/> Encephalitis <input type="radio"/> Meningitis <input type="radio"/> Acute flaccid paralysis <input type="radio"/> Febrile illness <input type="radio"/> Other: _____			Other information (immunocompromised, travel hx, hx of flavivirus infection, etc.):	
Other tests requested:			<b>This section for Laboratory use only. Date received and Accession Number</b>	
1 <sup>st</sup>	Specimen type and/or specimen source	Date Collected	1 <sup>st</sup>	
2 <sup>nd</sup>	Specimen type and/or specimen source	Date Collected	2 <sup>nd</sup>	
3 <sup>rd</sup>	Specimen type and/or specimen source	Date Collected	3 <sup>rd</sup>	

**Questions? Call Marin County Public Health Lab at Tel: 415-499-6849**

Submitting Physician \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

Submitting Facility \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_