

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 \leq 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 \geq 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:** \geq 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:

- 2nd Serum:** \geq 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: **San Diego County Public Health Laboratory, Mail Stop P572
3851 Rosecrans Street, Suite 716
San Diego, CA 92110-3115**

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

Patient's last name, first name:			Patient Information	
			Address _____	
Age <u>or</u> Sex (circle): Onset DOB: M F Date:			City _____ Zip _____ County _____	
Phone Number (____) _____				
Clinical findings: <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:			This section for Laboratory use only. Date received and Accession Number	
1 st	Specimen type and/or specimen source	Date Collected	1 st	
2 nd	Specimen type and/or specimen source	Date Collected	2 nd	
3 rd	Specimen type and/or specimen source	Date Collected	3 rd	

Questions? Please call Jill Giesick or Thelma Deguzman (619) 692-8500

Submitting Physician _____ Phone Number (____) _____

Submitting Facility _____ Phone Number (____) _____