West Nile Virus (WNV) Infection Case Report

California Department of Public Health
Viral and Rickettsial Disease Laboratory
850 Marina Bay Parkway
Richmond, CA 94804

Patient Information:

Last Name: _____ **First Name:**_____ **DOB:** ____/____/____ **Medical 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: _____

Exposures/Travel <u>within 4 wks of onset</u> (specify details):

Mosquito bites/exposure:	☐ Yes	☐ No	☐ Unk
Traveled outside of California:	☐ Yes	☐ No	☐ Unk
Traveled outside the U.S.:	☐ Yes	☐ No	☐ Unk
Ever traveled outside the U.S.:	☐ Yes	☐ No	☐ Unk

Other pertinent information (specify details):

Immunocompromised patient:	☐ Yes	☐ No	☐ Unk
Yellow fever vaccination: Date: ____/____/____	☐ Yes	☐ No	☐ Unk
Donated blood: Date: ____/____/____	☐ Yes	☐ No	☐ Unk
Donated organ: Date: ____/____/____	☐ Yes	☐ No	☐ Unk
Received blood: Date: ____/____/____	☐ Yes	☐ No	☐ Unk
Received organ: Date: ____/____/____	☐ Yes	☐ No	☐ Unk
Current pregnancy: Week of gestation: ____	☐ Yes	☐ No	☐ Unk
If infant, breast fed?	☐ Yes	☐ No	☐ Unk

Knowledge of WNV prior to illness:

Did patient do anything to avoid mosquito bites?	☐ Yes	☐ No	☐ Unk
If yes,			
- used insect repellent?	☐ Yes	☐ No	☐ Unk
- drained standing water near home?	☐ Yes	☐ No	☐ Unk

Other significant history (social, family, etc.):

_____
_____
_____

FAX this form to (619) 692-8558 or MAIL to: San Diego County Public Health Lab, 3851 Rosecrans St., San Diego, CA 92110
For questions regarding testing or specimens, call Jill Giesick or Thelma Deguzman (619) 692-8585