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

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: ____	Plt: ____
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: (530) 669-1549 **or MAIL to:** Yolo Co. Health Dept., 137 N. Cottonwood #2450, Woodland, CA 95695
For questions regarding testing or specimens, call Cynthia Jean (510) 307-8606

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

West Nile Virus (WNV) Infection Case Report
SUPPLEMENTAL INVESTIGATION FORM

Date Form Completed:___/___/____

Beginning in 2008, the Centers for Disease Control and Prevention (CDC) will collect surveillance data on selected underlying medical conditions and therapies that have previously been identified as risk factors for severe illness, hospitalization, and/or death among persons with WNV disease. Initial reports of WNV infections should be sent to the California Department of Public Health immediately after they have been confirmed. However, this supplemental investigation form is not time-sensitive and can be submitted at any time after a case has been reported.

Questions to Assess Underlying Medical Conditions and Medication Use

Patient Name (Last, First): _____ **DOB:**___/___/___

Clinical syndrome: ☐ Neuroinvasive disease ☐ West Nile fever ☐ Other clinical ☐ Asymptomatic infection

1. Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?

Diabetes ……..	☐ Yes	☐ No	☐ Unknown
High blood pressure (hypertension) ……	☐ Yes	☐ No	☐ Unknown
Heart attack (myocardial infarction) ……	☐ Yes	☐ No	☐ Unknown
Angina or coronary artery disease ……	☐ Yes	☐ No	☐ Unknown
Congestive heart failure (CHF) ……	☐ Yes	☐ No	☐ Unknown
Stroke ……	☐ Yes	☐ No	☐ Unknown
Chronic obstructive pulmonary disease (COPD) ..	☐ Yes	☐ No	☐ Unknown
Chronic liver disease ……..	☐ Yes	☐ No	☐ Unknown
Kidney failure or chronic kidney disease ……	☐ Yes	☐ No	☐ Unknown
Alcoholism ……	☐ Yes	☐ No	☐ Unknown
Bone marrow transplant ……	☐ Yes	☐ No	☐ Unknown
Solid organ transplant ……	☐ Yes	☐ No	☐ Unknown
If yes: What organ was transplanted?: _____			
What year was the transplant?: _____			
Cancer ……..	☐ Yes	☐ No	☐ Unknown
If yes: What type(s)?: _____			
What year were you diagnosed?: _____			
Are you currently being treated for cancer?:	☐ Yes	☐ No	☐ Unknown

2. Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection? ☐ Yes ☐ No ☐ Unknown

If yes: What condition(s)?: _____

3. At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?

Chemotherapy ……..	☐ Yes	☐ No	☐ Unknown
Other treatments for cancer ……..	☐ Yes	☐ No	☐ Unknown
Hemodialysis ……..	☐ Yes	☐ No	☐ Unknown
Other treatments for kidney disease ……	☐ Yes	☐ No	☐ Unknown
Oral or injected steroids (not inhaled or topical) ...	☐ Yes	☐ No	☐ Unknown
Insulin or other medications to treat diabetes ……	☐ Yes	☐ No	☐ Unknown
Medications to treat high blood pressure ……	☐ Yes	☐ No	☐ Unknown
Medications to treat coronary artery disease …...	☐ Yes	☐ No	☐ Unknown
Medications to treat congestive heart failure ……	☐ Yes	☐ No	☐ Unknown
Medications that suppress the immune system ….	☐ Yes	☐ No	☐ Unknown

4. Which of the following sources provided the information above? (check all that apply)

Patient	☐ Yes	☐ No	Family member/friend	☐ Yes	☐ No
Provider	☐ Yes	☐ No	Medical record	☐ Yes	☐ No

FAX this form: (530) 669-1549 **or MAIL to:** Yolo Co. Health Dept., 137 N. Cottonwood #2450, Woodland, CA 95695

Ver 1.0 (06/08)