

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
Paresis or paralysis Yes No Unk
Joint pain or arthritis Yes No Unk
Nausea or vomiting Yes No Unk
Diarrhea Yes No Unk
Other: _____

CSF Results	CBC Results
Date: ___/___/___	Date: ___/___/___
RBC: _____	WBC: _____
WBC: _____	%Diff: _____
%Diff: _____	HCT: _____
Protein: _____	Plt: _____
Glucose: _____	

Other lab results (MRI/CT, etc.): _____

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: ___/___/___

Past medical history:

Immunocompromised..... Yes No Unk
Specify: _____
Hypertension..... Yes No Unk
Diabetes Type ____ Yes No Unk

Other significant history/exposures: _____

West Nile Virus Test Results:				
Testing Laboratory	Specimen Type	Collection Date	Test Type	Result
Testing Laboratory	Specimen Type	Collection Date	Test Type	Result

FAX this form: (510) 307-8599 or MAIL to: CDPH/VRDL–West Nile Virus, 850 Marina Bay Parkway, Richmond CA 94804