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 to Disease Control at: (951) 358-5102 or (951) 358-5446
For questions regarding testing or specimens, call DOPH laboratory at (951) 358-5070