

# 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: \_\_\_/\_\_\_/\_\_\_  
Discharge to:  Home  SNF  Other Date of discharge from SNF/rehab: \_\_\_/\_\_\_/\_\_\_ Discharged to: \_\_\_\_\_

### 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  $\geq 38^{\circ}\text{C}$  .....  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:

Date: \_\_\_/\_\_\_/\_\_\_  
RBC: \_\_\_\_\_ WBC: \_\_\_\_\_  
%Diff: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ R \_\_\_\_\_ L  
Protein: \_\_\_\_\_ Gluc: \_\_\_\_\_

### CBC Results:

Date: \_\_\_/\_\_\_/\_\_\_  
WBC: \_\_\_\_\_  
%Diff: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ L  
HCT: \_\_\_\_\_  
Plt: \_\_\_\_\_

### 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

Please FAX this form to (714) 834-8196

For questions regarding testing or specimens, call Orange County Epidemiology at (714) 834-8180