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

For questions regarding testing or specimens, call Cynthia Jean (510) 307-8606