

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