

West Nile Virus (WNV) Infection Case Report

California Department of Health Services
Viral and Rickettsial Disease Laboratory
850 Marina Bay Parkway
Richmond, CA 94804

Patient Information:

Last Name: _____ **First Name:** _____ **DOB:** ___/___/___ **Medical 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:

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
Fever $\geq 38^\circ$ Yes No Unk
Headache Yes No Unk
Rash Yes No Unk
Stiff neck Yes No Unk
Muscle pain/weakness Yes No Unk
Altered consciousness Yes No Unk
Seizures Yes No Unk

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

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

Past medical history:

Hypertension: Yes No Unk
Diabetes Type _____ Yes No Unk
Other: _____

Exposures/Travel within 4 wks of onset (specify details):

Mosquito bites/exposure: Yes No Unk
Traveled outside of California: Yes No Unk
Traveled outside the U.S.: Yes No Unk
Ever traveled outside the U.S.: Yes No Unk

Other pertinent information (specify details):

Immunocompromised patient: Yes No Unk
Yellow fever vaccination: Yes No Unk
Date: ___/___/___
Donated blood: Yes No Unk
Date: ___/___/___
Donated organ: Yes No Unk
Date: ___/___/___
Received blood: Yes No Unk
Date: ___/___/___
Received organ: Yes No Unk
Date: ___/___/___
Current pregnancy: Yes No Unk
Week of gestation: _____

If infant, breast fed? Yes No Unk

Knowledge of WNV prior to illness:

Did patient do anything to avoid mosquito bites? Yes No Unk
If yes,
- used insect repellent? Yes No Unk
- drained standing water near home? Yes No Unk

Other significant history (social, family, etc.):

Questions regarding testing or specimens? Call the Sonoma County Public Health Laboratory at (707) 565-4711.

Fax this form to (707) 565-7839 or send with specimens to:

**Specimen Receiving
Public Health Laboratory
3313 Chanate Road
Santa Rosa, CA 95404**