West Nile Virus (WNV) Infection Case Report 2008

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 <u>within 4 wks of onset</u> (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
_______________	____________	___/___/___	_________	__________
_______________	____________	___/___/___	_________	__________

For questions regarding testing or specimens, call San Mateo Co. Disease Control & Prevention (650) 573-2346
Fax this form to (650) 573-2919 or mail to: San Mateo Co. Public Health Lab, 225 37th Avenue, San Mateo, Ca 94403

West Nile Virus (WNV) Infection Case Report
SUPPLEMENTAL INVESTIGATION FORM 2008

Date Form Completed:___/___/____

Beginning in 2008, the Centers for Disease Control and Prevention (CDC) will collect surveillance data on selected underlying medical conditions and therapies that have previously been identified as risk factors for severe illness, hospitalization, and/or death among persons with WNV disease. Initial reports of WNV infections should be sent to the California Department of Public Health immediately after they have been confirmed. However, this supplemental investigation form is not time-sensitive and can be submitted at any time after a case has been reported.

Questions to Assess Underlying Medical Conditions and Medication Use

Patient Name (Last, First): ____ **DOB:**___/___/___

Clinical syndrome: ☐ Neuroinvasive disease ☐ West Nile fever ☐ Other clinical ☐ Asymptomatic infection

1. **Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?**

Diabetes ………	☐ Yes	☐ No	☐ Unknown
High blood pressure (hypertension) ………	☐ Yes	☐ No	☐ Unknown
Heart attack (myocardial infarction) ………	☐ Yes	☐ No	☐ Unknown
Angina or coronary artery disease ………	☐ Yes	☐ No	☐ Unknown
Congestive heart failure (CHF) ………	☐ Yes	☐ No	☐ Unknown
Stroke ………	☐ Yes	☐ No	☐ Unknown
Chronic obstructive pulmonary disease (COPD) ..	☐ Yes	☐ No	☐ Unknown
Chronic liver disease ………	☐ Yes	☐ No	☐ Unknown
Kidney failure or chronic kidney disease ………	☐ Yes	☐ No	☐ Unknown
Alcoholism ………	☐ Yes	☐ No	☐ Unknown
Bone marrow transplant ………	☐ Yes	☐ No	☐ Unknown
Solid organ transplant ………	☐ Yes	☐ No	☐ Unknown

If yes: What organ was transplanted?: ____

What year was the transplant?: ____

Cancer ………	☐ Yes	☐ No	☐ Unknown

If yes: What type(s)?: ____

What year were you diagnosed?: ____

Are you currently being treated for cancer?: ☐ Yes ☐ No ☐ Unknown

2. **Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection?** ☐ Yes ☐ No ☐ Unknown

If yes: What condition(s)?: ____

3. **At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?**

Chemotherapy ………	☐ Yes	☐ No	☐ Unknown
Other treatments for cancer ………	☐ Yes	☐ No	☐ Unknown
Hemodialysis ………	☐ Yes	☐ No	☐ Unknown
Other treatments for kidney disease ………	☐ Yes	☐ No	☐ Unknown
Oral or injected steroids (not inhaled or topical) ...	☐ Yes	☐ No	☐ Unknown
Insulin or other medications to treat diabetes ……	☐ Yes	☐ No	☐ Unknown
Medications to treat high blood pressure ………	☐ Yes	☐ No	☐ Unknown
Medications to treat coronary artery disease ……...	☐ Yes	☐ No	☐ Unknown
Medications to treat congestive heart failure …….	☐ Yes	☐ No	☐ Unknown
Medications that suppress the immune system ….	☐ Yes	☐ No	☐ Unknown

4. **Which of the following sources provided the information above? (check all that apply)**

Patient	☐ Yes	☐ No	Family member/friend	☐ Yes	☐ No
Provider	☐ Yes	☐ No	Medical record	☐ Yes	☐ No

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