California Department of Public Health – Viral and Rickettsial Disease Laboratory

WEST NILE VIRUS SPECIMEN SUBMITTAL FORM

PLEASE USE ONE FORM PER PATIENT

West Nile virus testing is recommended on individuals with the following:

A. Encephalitis

B. Aseptic meningitis (Note: Consider enterovirus for individuals ≤ 18 years of age)

C. Acute flaccid paralysis; atypical Guillain-Barré Syndrome; transverse myelitis; or

D. Febrile illness compatible with West Nile fever* and lasting ≥ 7 days (must be seen by health care provider):

** The West Nile fever syndrome can be variable and often includes headache and fever (T≥38C). Other symptoms include rash, swollen lymph nodes, eye pain, nausea or vomiting. After initial symptoms, the patient may experience several days of fatigue and lethargy.*

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1. **Required specimens**:
   - ❑ **Acute Serum:** ≥ 2cc serum
   - ❑ **Cerebrospinal Fluid (CSF):** 1-2cc CSF if lumbar puncture is performed
2. If West Nile virus is highly suspected and acute serum is negative or inconclusive:
   - ❑ **2nd Serum:** ≥ 2 cc serum collected 3-5 days after acute serum

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- ❑ Refrigerated specimens should be sent on **cold pack** using an overnight courier
- ❑ If CSF is frozen, send on dry ice (all specimens may be sent on dry ice)
- ❑ Each specimen should be labeled with **date of collection**, **specimen type**, and **patient name**
- ❑ Please do not send specimens on Fridays (Specimen Receiving Hours: M-F 8-5)
- ❑ Send specimens to CDPH VRDL: **Specimen Receiving – West Nile**
  850 Marina Bay Parkway
  Richmond, CA 94804
- ❑ Local Public Health Laboratory West Nile **IFA/EIA IgM results** (or attach copy of results):

Specimen	Date Collected	IgM Assay Method	Results			
			Negative	Reactive	Indeterminate	Not Tested
		o IFA o EIA				
		o IFA o EIA				

**** IMPORTANT: THE INFORMATION BELOW MUST BE COMPLETED AND SUBMITTED WITH SPECIMENS ****

Patient's last name, first name:			**Patient Information** **Address** _____ **City**_____ **Zip**_____ **County**_____ **Phone Number (_____)**_____
Age or DOB:	Sex (circle): M F	Onset Date:	
Clinical findings: o Encephalitis o Meningitis o Acute flaccid paralysis o Febrile illness o Other: _____ Other tests requested:			Other information (immunocompromised, travel hx, hx of flavivirus infection, etc.):

	Specimen type and/or specimen source	Date Collected	**This section for Laboratory use only. Date received by VRDL and State Accession Number**
1st			1st
2nd			2nd
3rd			3rd

Questions? Call Cynthia Jean at (510) 307-8606

Submitting Physician_____ Phone Number (_____) _____

Submitting Facility_____ Phone Number (_____) _____