Orange County Health Care Agency
Epidemiology & Assessment
P.O. Box 6128
Santa Ana, CA 92706

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:** ____/____/____

Discharge to: ☐ Home ☐ SNF ☐ Other **Date of discharge from SNF/rehab:** ____/___/___ **Discharged to:**___________

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:
Date: ____/____/____
RBC: _____ WBC:______
%Diff: ______S ______M
______R ______L
Protein: ______ Gluc:______

CBC Results:
Date: ____/____/____
WBC: ______
%Diff: ___S ___ M ___L
HCT: ______
Plt: ______

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
______________	____________	___/___/___	_________	__________
______________	____________	___/___/___	_________	__________

Please FAX this form to (714) 834-8196

For questions regarding testing or specimens, call Orange County Epidemiology at (714) 834-8180