State of California – Health and Human Services Agency

California Department of Public Health

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
		___/___/___		
		___/___/___		

Please FAX to Contra Costa Public Health: (925) 313-6465

(06/12)