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West Nile

COUNTY

FOR STATE USE ONLY #

___/___/___ case report ☐ confirmed ☐ presumptive

☐ Provider ☐ Patient Med Record # _____ Date investigation initiated: __ /__ /__

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County Zip

e-mail address_____

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT *(check all that apply)*

☐ Lab ☐ Infection Control Practitioner

☐ Physician ☐ _____

Name _____

Phone _____ Date ___/___/___ *(first report)*

Name _____ *(if different)*

Phone _____

OK to talk to patient? ☐

DEMOGRAPHICS

SEX

☐ female ☐ male

DATE OF BIRTH

____/____/____
mm dd yy

HISPANIC ☐ yes ☐ no ☐ unknown

RACE

☐ White ☐ American Indian
☐ Black ☐ Asian/Pacific Islander
☐ unknown ☐ refused to answer
☐ other _____

Worksites/school/daycare _____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic: ☐ yes ☐ no ☐ unk

if yes, ONSET on ____/____/____
mm dd yy

Check all symptoms that apply:

headache	☐ yes	☐ no	☐ unk
fever	☐ yes	☐ no	☐ unk
meningitis	☐ yes	☐ no	☐ unk
diarrhea	☐ yes	☐ no	☐ unk
vomiting	☐ yes	☐ no	☐ unk
weakness	☐ yes	☐ no	☐ unk
flacid paralysis	☐ yes	☐ no	☐ unk
rash	☐ yes	☐ no	☐ unk
changed mental state	☐ yes	☐ no	☐ unk

LABORATORY DATA

	PHL	Other laboratories
Spec #	_____	_____
PCR	☐ pos ☐ neg ☐ equivocal	
ELISA	☐ pos ☐ neg ☐ equivocal	
IgM	_____(OD)	IgG_____(OD)

Hospitalized overnight? ☐ yes ☐ no ☐ unk

Name of hospital _____

Date of admission ____/____/____ date of discharge ____/____/____
mm dd yy mm dd yy

Transferred to/from another hospital: ☐ yes ☐ no ☐ unk

Transfer hospital name _____

Outcome: ☐ survived ☐ died ☐ unk date of death ____/____/____ (mm/dd/yy)

Was autopsy performed? ☐ yes ☐ no ☐ unk date performed ____/____/____
mm dd yy

Autopsy facility _____phone_____
results consistent with WNV_____

PATIENT'S NAME

INFECTION TIMELINE

EXPOSURE PERIOD

Enter onset date in heavy box. Count backwards to figure probable exposure period.

days from onset: **-15** -3 onset

calendar dates:

Risk Factors & Possible Sources of Infection During Exposure Period

Does the patient remember getting any mosquito bite(s) 30 days prior to onset? ☐ yes ☐ no ☐ unk

If yes, where and whe (mm/dd/yy)

_____/____/____

_____/____/____

_____/____/____

If an infant, has the patient been breastfed within 30 days prior to the onset of illness?

☐ yes ☐ no ☐ unk

Does the patient work at any facility handling blood products?

☐ yes ☐ no ☐ unk *if yes*, explain

Has the patient received a blood product or transplant within 30 days prior to the onset of illness? ☐ yes ☐ no ☐ unk

Has the patient donated blood, plasma or an organ recently ? ☐ yes ☐ no ☐ unk *if yes*, explain

Has the patient traveled outside the U.S. in the 30 days prior to illness?

☐ yes ☐ no ☐ unk

If yes, list destination(s) and dates Duration of stay (mm/dd/yy)

_____from _____/_____/_____to _____/_____/_____

_____from _____/_____/_____to _____/_____/_____

_____from _____/_____/_____to _____/_____/_____

Did the patient travel outside his/her home state within (30 days) before onset?

☐ yes ☐ no ☐ unk

If yes, list destination(s) and dates Duration of stay (mm/dd/yy)

_____ _from _____/_____/_____to _____/_____/_____

_____from _____/_____/_____to _____/_____/_____

Pre-existing conditions

diabetes	☐ yes	☐ no	☐ unk
high blood pressure	☐ yes	☐ no	☐ unk
heart attack	☐ yes	☐ no	☐ unk
angina / coronary heart disease	☐ yes	☐ no	☐ unk
congestive heart failure	☐ yes	☐ no	☐ unk
stroke	☐ yes	☐ no	☐ unk
COPD	☐ yes	☐ no	☐ unk
chronic liver disease	☐ yes	☐ no	☐ unk
kidney disease or failure	☐ yes	☐ no	☐ unk
alcoholism	☐ yes	☐ no	☐ unk
bone marrow transplant	☐ yes	☐ no	☐ unk
solid organ transplant	☐ yes	☐ no	☐ unk

if yes, what organ was transplanted?_____

what year?_____

cancer ☐ yes ☐ no ☐ unk

if yes, what type(s)?_____

year of diagnosis _____

Before your West Nile infection, did a health care provider tell you that you had a medical condition that limited your ability to fight an infection?

☐ yes ☐ no ☐ unk

if yes, what condition(s)?_____

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	☐ unk
Other treatments for cancer	☐ yes	☐ no	☐ unk
Hemodialysis	☐ yes	☐ no	☐ unk
Other treatments for kidney disease	☐ yes	☐ no	☐ unk
Steroids (oral or injected)	☐ yes	☐ no	☐ unk
Insulin or other medications to treat diabetes	☐ yes	☐ no	☐ unk
Medications to treat high blood pressure	☐ yes	☐ no	☐ unk
Medications to treat coronary artery disease	☐ yes	☐ no	☐ unk
Medications to treat congestive heart failure	☐ yes	☐ no	☐ unk
Medications that suppress the immune system	☐ yes	☐ no	☐ unk

ADMINISTRATION

June 2008

Remember to copy patient's name to the top of this page.

Initial report sent to OHS on ____/____/____

Completed by _____ Date _____ Phone _____Case investigation sent to OHS on ____/____/____