



West Nile Virus Disease

County _____

LHJ Use ID _____
 Reported to DOH Date ____/____/____
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____
 OK to talk to case? Yes No DK Date of interview ____/____/____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Birth date ____/____/____ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms

Y	N	DK	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures new with disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors or hand shakes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe fatigue or malaise

Hospitalization

Y	N	DK	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalized at least overnight for this illness

Hospital name _____
 Admit date ____/____/____ Discharge date ____/____/____

Y	N	DK	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Died from illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autopsy

 Place of death _____
 Death date ____/____/____

Predisposing Conditions (CDC supplemental form)

Y	N	DK	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous flavivirus infection (e.g., dengue, SLE)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient previously told that they had:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina/coronary artery dis.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic obst. lung disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic liver dis.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic kidney dis. /failure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone marrow transplant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunocompromising disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current prescriptions or treatment (meds)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other cancer meds: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemodialysis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other kidney meds: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral or injected steroids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure meds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin, other diabetes treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CAD meds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune suppressing treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHFD meds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant if yes, weeks: ____ outcome: _____

Vaccinations

Y	N	DK	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Japanese encephalitis or yellow fever vaccination

 Type: _____ Date ____/____/____

Laboratory

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

Specimen type _____ Collection date ____/____/____
 Specimen type _____ Collection date ____/____/____

P	N	I	O	N	T	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CSF obtained
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Profile: wbc ____ (% lymph ____ % neutr ____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rbc ____ prot ____ gluc ____

 WNV IgM in serum by EIA/MIA/IFA with no other testing [Probable]
 WNV IgM in CSF by EIA/MIA/IFA with no other testing [Probable]
 WNV culture or PCR (clinical specimen)
 WNV antibodies with ≥ 4-fold rise in quantitative titer (serum pair)
 WNV IgM in serum with confirmatory assay (e.g. PRNT) in same or later specimen
 WNV IgM in CSF and negative IgM in CSF for other arboviruses
 Tested at: WA PHL CDC Other PHL
 Commercial Other

Clinical Findings

Clinical syndrome: Encephalitis / meningoencephalitis
 Meningitis WNV fever Jaundice / hepatitis
 Multi-organ failure Asymptomatic Other Unk

Y	N	DK	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Presumptive viremic donor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Altered mental status
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acute flaccid paralysis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological abnormalities: _____

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

Days from onset: -14 -2

Calendar dates:

o
n
s
e
t

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____ _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Infant <input type="checkbox"/> Birth mother had febrile illness <input type="checkbox"/> Infected in utero <input type="checkbox"/> Breast fed</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> In area with mosquito activity or remember bite Date: ___/___/_____ Specific location (e.g., address, intersection) _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Laboratory acquired <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-lab occupationally acquired Job: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood transfusion or blood products (e.g. IG, factor concentrates) Date of receipt: ___/___/_____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Organ or tissue transplant recipient Date of receipt: ___/___/_____</p>
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Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PUBLIC HEALTH ISSUES

Y N DK NA

Did case donate blood products in the 30 days before symptom onset Date: ___/___/_____
 Agency and location: _____
 Specify type of donation: _____

Did case donate organs or tissue (including ova or semen) in the 30 days before symptom onset
 Date: ___/___/_____
 Agency and location: _____
 Specify type of donation: _____

PUBLIC HEALTH ACTIONS

Breastfeeding education provided
 Notify blood or tissue bank
 Other, specify: _____

NOTES

Investigator _____ Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____	Record complete date ___/___/___