



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 Death date ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autopsy Place of death _____

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

P	N	I	O	N	T	
<input type="checkbox"/>	CSF obtained					
<input type="checkbox"/>	Profile: wbc ____ (% lymph ____ % neutr ____) rbc ____ prot ____ gluc ____					
<input type="checkbox"/>	WNV IgM in serum by EIA/MIA/IFA with no other testing [Probable]					
<input type="checkbox"/>	WNV IgM in CSF by EIA/MIA/IFA with no other testing [Probable]					
<input type="checkbox"/>	WNV culture or PCR (serum, tissue, <u>not</u> CSF)					
<input type="checkbox"/>	WNV culture or PCR (CSF)					
<input type="checkbox"/>	WNV antibodies with ≥ 4-fold rise in quantitative titer (serum pair)					
<input type="checkbox"/>	WNV IgM in serum with confirmatory assay (e.g. PRNT) in same or later specimen					
<input type="checkbox"/>	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 **PUBLIC HEALTH ACTIONS**

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did case donate blood products in the 30 days before symptom onset Date: ____/____/____ Agency and location: _____ Specify type of donation: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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: _____</p>	<p><input type="checkbox"/> Breastfeeding education provided <input type="checkbox"/> Notify blood or tissue bank <input type="checkbox"/> Other, specify: _____</p>
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NOTES

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