

# West Nile Virus

Investigator: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone number: \_\_\_\_\_

### FOR STATE USE ONLY

Status:  Confirmed  Suspect  
 Probable  Not a case

Reviewer initials: \_\_\_\_\_  
 Referred to another state: \_\_\_\_\_

## CASE

Last name: \_\_\_\_\_  
 First and middle name: \_\_\_\_\_  
 Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
 Address line: \_\_\_\_\_  
 Zip: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ County: \_\_\_\_\_  
 Phone: ( )- - Type: \_\_\_\_\_  
 Long-term care resident:  Yes  No  Unknown  
 Facility name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_  
 Gender:  Female  Male  Other \_\_\_\_\_  
 Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Marital status:  Single  Married  Separated  
 Divorced  Parent with partner  Widowed  
 Race:  American Indian or Alaskan Native  Unknown  
 Black or African American  White  
 Hawaiian or Pacific Islander  Asian  
 Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown  
 Parent/Guardian name: \_\_\_\_\_  
 Parent/Guardian phone: ( )- - Type: \_\_\_\_\_

## EVENT

Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown  
 Date of death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Event exception:  Case could not be found  
 Case could not be interviewed  
 Case refused interview  
 Other – see notes  
 Outbreak related:  Yes  No  Unknown  
 Outbreak name: \_\_\_\_\_  
 Exposure setting: \_\_\_\_\_  
 Epi-linked:  Yes  No  Unknown  
 Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown  
 State: \_\_\_\_\_ Country: \_\_\_\_\_

Healthcare provider information

Last name: \_\_\_\_\_  
 First name: \_\_\_\_\_  
 Provider title:  ARNP  MD  PA  
 DO  NP  
 Facility name: \_\_\_\_\_  
 Address line 1: \_\_\_\_\_  
 Address line 2: \_\_\_\_\_  
 Zip code: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ County: \_\_\_\_\_  
 Phone: ( )- - Type: \_\_\_\_\_

## LABORATORY FINDINGS

Laboratory: \_\_\_\_\_ Specimen source: \_\_\_\_\_ Test type:  Serology (EIA/ELISA/MIA)  
 Serology (IFA)  
 PRNT  
 PCR  Other \_\_\_\_\_  
 Accession #: \_\_\_\_\_ Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result type:  Preliminary  Final  
 Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Test type:  Acute  IgM  
 Convalescent  IgG Result:  Negative  Equivocal  
 Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Organism: **West Nile virus**  Positive  Indeterminate

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 Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Organism: **West Nile virus**  Positive  Indeterminate

Laboratory: _____	Specimen source: _____	Test type: <input type="checkbox"/> Serology (EIA/ELISA/MIA) <input type="checkbox"/> Serology (IFA) <input type="checkbox"/> PRNT <input type="checkbox"/> PCR <input type="checkbox"/> Other _____
Accession #: _____	Result date: ____/____/____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final
Collection date: ____/____/____	Test type: <input type="checkbox"/> Acute <input type="checkbox"/> IgM <input type="checkbox"/> Convalescent <input type="checkbox"/> IgG	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Date received: ____/____/____	Organism: <b>West Nile virus</b>	

**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____/____/____	Address: _____
Date worked to: ____/____/____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____/____/____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**HOSPITALIZATIONS**

Was the case hospitalized?  Yes  No  Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Isolation type (entry): _____
Admission date: ____/____/____	Discharge date: ____/____/____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Current isolation type: _____	

**CLINICAL INFO & DIAGNOSIS**

<b>Physician diagnosis:</b> <input type="checkbox"/> Encephalitis <input type="checkbox"/> Meningitis <input type="checkbox"/> Meningoencephalitis <input type="checkbox"/> Fever	<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Hepatitis/jaundice <input type="checkbox"/> Multi-system organ failure <input type="checkbox"/> Other _____	<b>Clinical classification:</b> <input type="checkbox"/> Neuroinvasive <input type="checkbox"/> Non-neuroinvasive
<b>Symptoms:</b> <input type="checkbox"/> Acute flaccid paralysis <input type="checkbox"/> Altered mental state <input type="checkbox"/> Anorexia <input type="checkbox"/> Coma <input type="checkbox"/> Confusion <input type="checkbox"/> Cranial nerve palsies	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Double vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Gait/balance difficulty	<input type="checkbox"/> Headache <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Nausea <input type="checkbox"/> Photophobia <input type="checkbox"/> Rash <input type="checkbox"/> Stiff neck <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Tremors <input type="checkbox"/> Vertigo <input type="checkbox"/> Vomiting <input type="checkbox"/> Other symptoms: _____

**Pre-existing Conditions**

Before your West Nile virus (WNV) infection, did a health care provider ever tell he/she had any of the following medical conditions?

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Kidney disease or failure
<input type="checkbox"/> High blood pressure (hypertension)	<input type="checkbox"/> Stroke	<input type="checkbox"/> Bone marrow transplant
<input type="checkbox"/> Heart attack (myocardial infarction)	<input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Angina or coronary artery disease	<input type="checkbox"/> Chronic liver disease	<input type="checkbox"/> Case had none of the conditions listed

Before WNV infection, did the case ever have a solid organ transplant?  Yes  No  Unk

If yes, what organ was transplanted: \_\_\_\_\_

If yes, what year was the transplant: \_\_\_\_\_

Before WNV infection, has the case ever had cancer?  Yes  No  Unk

If yes, what cancer type(s): \_\_\_\_\_

If yes, what year were you diagnosed: \_\_\_\_\_

If yes, are you currently being treated for cancer:  Yes  No  Unk

Before WNV infection, did the case have any medical condition that limited his/her ability to fight infection?  Yes  No  Unk

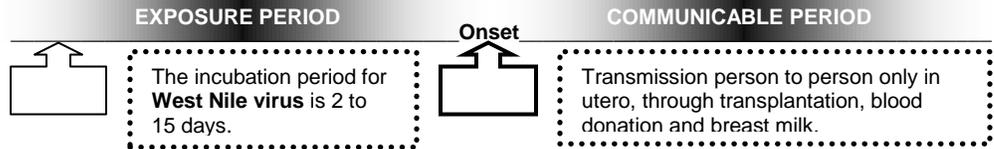
If yes, what condition: \_\_\_\_\_

At the time WNV infection was diagnosed, was the case taking any of the following types of prescription medications or treatments?

- Chemotherapy, Oral or injected steroids, Medications to treat coronary artery disease, Other treatments for cancer, Inhaled steroids, Medications to treat congestive heart failure, Hemodialysis, Insulin or other medications to treat diabetes, Medications that suppress the immune system, Other treatments for kidney disease, Medications to treat high blood pressure, Case was not on any medications/treatments listed

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Ever vaccinated for Yellow fever  Yes  No  Unk

Ever vaccinated for Japanese encephalitis (JE)?  Yes  No  Unk

If yes, list MOST RECENT vaccination information ONLY:

Disease: Yellow fever, Date vaccinated: / /, Lot #: , Vaccine type: , Manufacturer:

Disease: Japanese encephalitis (JE), Date vaccinated: / /, Lot #: , Vaccine type: , Manufacturer:

Risk Factors/Travel Information

In the 2 to 15 days prior to onset of symptoms did the case:

Traveled within Iowa? City in Iowa: , Traveled within U.S.? State: City: , Traveled outside U.S.? Country:

Departure date: / /, Return date: / /, Departure date: / /, Return date: / /, Departure date: / /, Return date: / /

Exposed to mosquitoes:  Yes  No  Unk

Use a mosquito repellent:  Yes  No  Unk If yes, how often? Always, Most of the time, sometimes, Never. If yes, what type? DEET, Lemon eucalyptus oil, Picaridin, Other

If the patient is female, was she:

Breastfeeding?  Yes  No  Unk

In the 30 days prior to onset of symptoms did the case:

Donate blood, blood products, organs or tissues?  Yes  No  Unk

Date donated: / /

Receive blood or blood products?  Yes  No  Unk

Date received: / /

Receive organs or tissue?  Yes  No  Unk

Date received: / /

Case acquired infection: Naturally, Transplantation, Transfusion, Trans-placental, Breastfeeding, Occupationally, Unknown

