West Nile Virus

Investigator: ______

Agency: ______ Phone number: ______

FOR STATE USE ONLY

Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ 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 ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ 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 ☐ DO ☐ NP ☐ PA

Facility name: ______

Address line 1: ______

Address line 2: ______

Zip code: ______ City: ______

State: ______ County: ______

Phone : ( )- - Type: ______

LABORATORY FINDINGS

Laboratory: ______ Specimen source: ______

Accession #: ______ Result date: / /

Collection date: / / Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG

Date received: / / Organism: **West Nile virus**

Test type: ☐ Serology (EIA/ELISA/MIA) ☐ Serology (IFA) ☐ PRNT ☐ PCR ☐ Other ______

Result type: ☐ Preliminary ☐ Final

Result: ☐ Negative ☐ Equivocal ☐ Positive ☐ Indeterminate

Laboratory: ______ Specimen source: ______

Accession #: ______ Result date: / /

Collection date: / / Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG

Date received: / / Organism: **West Nile virus**

Test type: ☐ Serology (EIA/ELISA/MIA) ☐ Serology (IFA) ☐ PRNT ☐ PCR ☐ Other ______

Result type: ☐ Preliminary ☐ Final

Result: ☐ Negative ☐ Equivocal ☐ Positive ☐ Indeterminate

Laboratory: ____________ Specimen source: ____________ Test type: ☐ Serology (EIA/ELISA/MIA) ☐ Serology (IFA) ☐ PRNT ☐ PCR ☐ Other ______

Accession #: ____________ Result date: __/__/__

Collection date: __/__/__ Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG Result type: ☐ Preliminary ☐ Final

Date received: __/__/__ Organism: **West Nile virus** Result: ☐ Negative ☐ Equivocal ☐ Positive ☐ Indeterminate

OCCUPATIONS

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

Occupation type: ____________ Job title: ____________

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________

Date worked from: __/__/__ Address: ____________

Date worked to: __/__/__ Zip code: ____________

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ________ State: ______ County: ________

Date removed: __/__/__ Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: ____________ Job title: ____________

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________

Date worked from: __/__/__ Address: ____________

Date worked to: __/__/__ Zip code: ____________

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ________ State: ______ County: ________

Date removed: __/__/__ Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ____________ Admission date: __/__/__ Discharge date: __/__/__

Days hospitalized :

CLINICAL INFO & DIAGNOSIS

Physician diagnosis: ☐ Encephalitis ☐ Meningitis ☐ Meningoencephalitis ☐ Fever ☐ Asymptomatic ☐ Hepatitis/jaundice ☐ Multi-system organ failure ☐ Other ______

Clinical classification: ☐ Neuroinvasive ☐ Non-neuroinvasive

Symptoms:

☐ Acute flaccid paralysis ☐ Altered mental state ☐ Anorexia ☐ Coma ☐ Confusion ☐ Cranial nerve palsies

☐ Diarrhea ☐ Double vision ☐ Eye pain ☐ Fatigue ☐ Fever ☐ Gait/balance difficulty

☐ Headache ☐ Joint pain ☐ Muscle pain ☐ Nausea ☐ Photophobia ☐ Rash

☐ Stiff neck ☐ Swollen lymph nodes ☐ Tremors ☐ Vertigo ☐ Vomiting ☐ Other symptoms: ____________

If fever, highest known fever: °F/C

Disease was identified through routine blood donation screening by blood collection agency: ☐ Yes ☐ No ☐ Unknown

Date of donation: __/__/__

All lab testing by: ☐ Public health laboratory (state or CDC) only ☐ Public health and commercial laboratory ☐ Commercial laboratory only ☐ Unk

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?

☐ Diabetes
☐ High blood pressure (hypertension)
☐ Heart attack (myocardial infarction)
☐ Angina or coronary artery disease
☐ Congestive heart failure
☐ Stroke
☐ Chronic obstructive pulmonary disease (COPD)
☐ Chronic liver disease
☐ Kidney disease or failure
☐ Bone marrow transplant
☐ Alcoholism
☐ 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

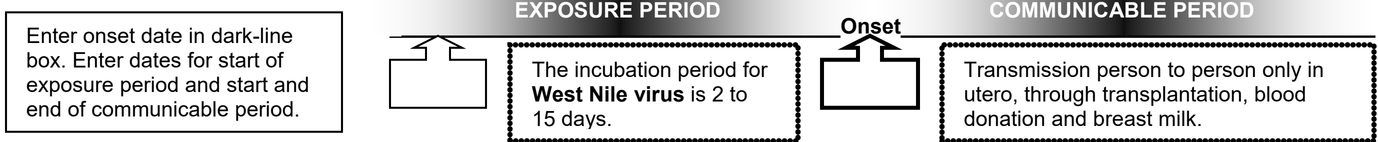
If yes, what condition: ______________

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

☐ Chemotherapy
☐ Other treatments for cancer
☐ Hemodialysis
☐ Other treatments for kidney disease
☐ Oral or injected steroids
☐ Inhaled steroids
☐ Insulin or other medications to treat diabetes
☐ Medications to treat high blood pressure
☐ Medications to treat coronary artery disease
☐ Medications to treat congestive heart failure
☐ Medications that suppress the immune system
☐ 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

Source of medical information: ☐ Family ☐ Medical chart ☐ Patient interview ☐ Primary care provider

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? ☐ Yes ☐ No ☐ Unk City in Iowa: ______________ Departure date: ____/____/____ Return date: ____/____/____

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ________ City: ________ Departure date: ____/____/____ Return date: ____/____/____

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: ______________ 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 ☐ Transfusion ☐ Breastfeeding ☐ Transplantation ☐ Trans-placental ☐ Unknown

Lab acquired infection: ☐ Yes ☐ No ☐ Unk

Occupationally in non-lab setting: ☐ Yes ☐ No ☐ Unk

NOTES: