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 ☐ DO ☐ NP ☐ PA

Facility name:

Address line 1:

Address line 2:

Zip code: City:

State: County:

Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory:

Accession #:

Collection date: / /

Date received: / /

Specimen source:

Result date: / /

Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG

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:

Accession #:

Collection date: / /

Date received: / /

Specimen source:

Result date: / /

Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG

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

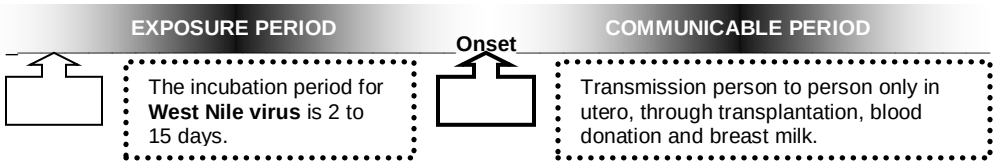
If yes, what condition: _____

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 ☐ Transplantation ☐ Transfusion ☐ Trans-placental ☐ Breastfeeding ☐ Unknown

Lab acquired infection: ☐ Yes ☐ No ☐ Unk

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

NOTES: