

Case complete

Syndrome \_\_\_\_\_ Date \_\_\_\_\_

# West Nile Virus Infection Case Investigation Form

How was this information collected?  Case or Relative  Physician or Hospital  No follow up

CEDRS # \_\_\_\_\_

## Demographic Information

Name: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

<b>Sex:</b>	<b>Date of Birth:</b>	<b>Age:</b>	<b>Race:</b>	<b>Ethnicity:</b>
<input type="checkbox"/> Male	Mo. Day Year	_____	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Female	_____ - _____ - _____	_____	<input type="checkbox"/> Black	<input type="checkbox"/> Non-Hispanic
<input type="checkbox"/> Unknown			<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Unknown
			<input type="checkbox"/> Asian	
			<input type="checkbox"/> Pacific Islander/Hawaiian	
			<input type="checkbox"/> Other: _____	
			<input type="checkbox"/> Unknown	

## Case Information

Onset Date: \_\_\_\_\_ Physician Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Date Reported: \_\_\_\_\_ Case Status:  Confirmed  Probable  Suspect  Unknown  Not a Case

Hospitalized:  Yes  No  Unknown Hospital Name: \_\_\_\_\_

Outcome:  Alive  Deceased  Unknown Date of Death: \_\_\_\_\_

Physician Diagnosed Syndrome: \_\_\_\_\_

## Lab/Medical Testing

**TEST 1:**  ELISA IgM  ELISA IgG  RT-PCR  NAAT

Specimen:  CSF  Serum Collection Date: \_\_\_\_\_

Test Result:  Positive  Negative  Pending Result Date: \_\_\_\_\_

**TEST 2:**  ELISA IgM  ELISA IgG  RT-PCR  NAAT

Specimen:  CSF  Serum Collection Date: \_\_\_\_\_

Test Result:  Positive  Negative  Pending Result Date: \_\_\_\_\_

## Extended Record

Clinical Syndrome:  Asymptomatic  Uncomplicated Fever  Meningitis  Encephalitis  Meningoencephalitis

Acute Flaccid Paralysis (Physician Diagnosed):  Yes  No  Unknown

Organ Donor/Transplant:  None  Organ Donor  Organ Recipient Organ(s): \_\_\_\_\_ Year: \_\_\_\_\_

Bone Marrow Transplant:  Yes  No  Unknown Date: \_\_\_\_\_

Has patient donated blood?  Yes  No  Unknown If yes, date(s): \_\_\_\_\_ Location: \_\_\_\_\_

If yes, was the patient ID'ed by blood donor screening?  Yes  No  Unk Date(s): \_\_\_\_\_

Did patient receive blood within four weeks of onset?  Yes  No  Unknown If yes, date(s): \_\_\_\_\_

Location: \_\_\_\_\_

Is patient pregnant?  Yes  No  Unknown If yes, expected delivery date: \_\_\_\_\_

Infant, if yes is s/he being breastfed?  Yes  No  Unknown Infected in utero?  Yes  No  Unknown

## Extended Record – continued

### Cardiac Risk Factors:

Hypertension?  Yes  No  Unknown      Hypertension Medications?  Yes  No  Unknown  
Heart Attack?  Yes  No  Unknown      Congestive Heart Medications?  Yes  No  Unknown  
Coronary Artery?  Yes  No  Unknown      Coronary Artery Medications?  Yes  No  Unknown

### Chronic Risk Factors:

Stroke?  Yes  No  Unknown      Liver Disease?  Yes  No  Unknown  
Diabetes?  Yes  No  Unknown      Insulin?  Yes  No  Unknown  
COPD?  Yes  No  Unknown      Alcoholism?  Yes  No  Unknown  
Steroids?  Yes  No  Unknown

### Cancer Risk Factors:

Cancer?  Yes  No  Unknown      Type of Cancer: \_\_\_\_\_  
Year of Cancer: \_\_\_\_\_      Other Cancer?  Yes  No  Unknown  
Cancer Treatment?  Yes  No  Unknown      Chemo?  Yes  No  Unknown  
Immune Suppressed?  Yes  No  Unknown      Immune Suppressed Condition: \_\_\_\_\_

### Kidney Disease Risk Factors :

Hemodialysis?  Yes  No  Unknown  
Kidney Disease?  Yes  No  Unknown      Other Kidney Treatment?  Yes  No  Unknown

### Medication Risk Factors :

Immune Suppress Medications?  Yes  No  Unknown

### Source of Risk Factor Information :

Patient?  Yes  No  Unknown      Family?  Yes  No  Unknown  
Provider?  Yes  No  Unknown      Medical Record?  Yes  No  Unknown

## Interviewer Comments

Fever

Headache

Chills

Body aches

Bone/joint pain

Rash

Swollen lymph glands

Muscle weakness

Severe fatigue

Lost appetite

Eye pain

Muscle tremors

*Other:*

### Neuroinvasive?

changed mental status delirium disorientation coma stiff neck severe muscle weakness

change in hearing (sensitivity, loss) memory problems

*Other:*

Paralysis?

Bit by mosquitoes (When)?

Geographic location (Where)?

Investigator:

Date report received:

Date report closed:

