Washington State Department of HEALTH

West Nile Virus Disease

County

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ ☐ Years ☐ Months

Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

☐ Classification pending ☐ Confirmed ☐ Investigation in progress ☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status

☐ Complete ☐ Complete – not reportable to DOH ☐ Unable to complete Reason _____ ☐ In progress

Dates: **Investigation start** ___/___/__ Investigation complete ___/___/__ Record complete ___/___/__ **Case complete** ___/___/__

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: ☐ Female ☐ Male ☐ Other ☐ Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Patient declined to respond ☐ Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race ☐ Amer Ind/AK Native (***specify***: ☐ Amer Ind ***and/or*** ☐ AK Native) ☐ Asian ☐ Black or African American ☐ Native HI/Pacific Islander (***specify***: ☐ Native HI ***and/or*** ☐ Pacific Islander) ☐ White ☐ Patient declined to respond ☐ Unk

Additional race information:

☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Asian Indian ☐ Bamar/Burman/Burmese ☐ Bangladeshi ☐ Bhutanese
☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Chinese ☐ Congolese ☐ Cuban ☐ Dominican ☐ Egyptian
☐ Eritrean ☐ Ethiopian ☐ Fijian ☐ Filipino ☐ First Nations ☐ Guamanian or Chamorro ☐ Hmong/Mong
☐ Indigenous-Latino/a or Indigenous-Latinx ☐ Indonesian ☐ Iranian ☐ Iraqi ☐ Japanese ☐ Jordanian ☐ Karen
☐ Kenyan ☐ Khmer/Cambodian ☐ Korean ☐ Kuwaiti ☐ Lao ☐ Lebanese ☐ Malaysian ☐ Marshallese ☐ Mestizo
☐ Mexican/Mexican American ☐ Middle Eastern ☐ Mien ☐ Moroccan ☐ Nepalese ☐ North African ☐ Oromo
☐ Pakistani ☐ Puerto Rican ☐ Romanian/Rumanian ☐ Russian ☐ Samoan ☐ Saudi Arabian ☐ Somali
☐ South African ☐ South American ☐ Syrian ☐ Taiwanese ☐ Thai ☐ Tongan ☐ Ugandan ☐ Ukrainian
☐ Vietnamese ☐ Yemeni ☐ Other: _____

What is your (your childs) preferred language? Check one:

☐ Amharic ☐ Arabic ☐ Balochi/Baluchi ☐ Burmese ☐ Cantonese ☐ Chinese (unspecified) ☐ Chamorro ☐ Chuukese
☐ Dari ☐ English ☐ Farsi/Persian ☐ Fijian ☐ Filipino/Pilipino ☐ French ☐ German ☐ Hindi ☐ Hmong ☐ Japanese
☐ Karen ☐ Khmer/Cambodian ☐ Kinyarwanda ☐ Korean ☐ Kosraean ☐ Lao ☐ Mandarin ☐ Marshallese ☐ Mixteco
☐ Nepali ☐ Oromo ☐ Panjabi/Punjabi ☐ Pashto ☐ Portuguese ☐ Romanian/Rumanian ☐ Russian ☐ Samoan
☐ Sign languages ☐ Somali ☐ Spanish/Castilian ☐ Swahili/Kiswahili ☐ Tagalog ☐ Tamil ☐ Telugu ☐ Thai ☐ Tigrinya
☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ Other language: _____ ☐ Patient declined to respond ☐ Unknown

Interpreter needed ☐ Yes ☐ No ☐ Unk

Case Name _____ LHJ Case ID _____

EMPLOYMENT AND SCHOOL

Employed ☐ Yes ☐ No ☐ Unk Occupation _____ Industry _____

Employer _____ Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk

Type of school ☐ Preschool/day care ☐ K-12 ☐ College ☐ Graduate School ☐ Vocational ☐ Online ☐ Other

School name _____ School address _____

City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____

OK to talk to patient (If Later, provide date) ☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___ ☐ Complete ☐ Partial ☐ Unable to reach ☐ Patient could not be interviewed

Alternate contact: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Friend ☐ Other _____

Name _____ Phone _____

Outbreak related ☐ Yes ☐ No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk **Symptom Onset ___/___/___** ☐ **Derived** Diagnosis date ___/___/___

Clinical Features

Primary clinical syndrome ☐ Asymptomatic ☐ Uncomplicated fever ☐ Meningitis ☐ Encephalitis/meningoencephalitis
☐ Other neuroinvasive ☐ Hepatitis/jaundice ☐ Multi-organ failure
☐ Kidney (renal) abnormality or failure ☐ Unk
☐ Other clinical syndrome _____

Y	N	Unk	
☐	☐	☐	Asymptomatic (no clinical illness)
☐	☐	☐	**Presumptive viremic donor**
☐	☐	☐	**Any fever, subjective or measured** If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF

If no,

Y	N	Unk	
☐	☐	☐	Used OTC medications that reduced fever
☐	☐	☐	Other potential reason for lack of fever _____

Y	N	Unk	
☐	☐	☐	**Chills or rigors**
☐	☐	☐	Rash
☐	☐	☐	Headache
☐	☐	☐	Fatigue
☐	☐	☐	Malaise
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Diarrhea *(3 or more loose stools within a 24 hour period)*
☐	☐	☐	Myalgia (muscle aches or pain)
☐	☐	☐	Arthralgia (joint pain)
☐	☐	☐	Arthritis
☐	☐	☐	Abdominal pain or cramps
☐	☐	☐	Nuchal rigidity (stiff neck)
☐	☐	☐	Neuroinvasive illness
☐	☐	☐	Paresis
☐	☐	☐	Abnormal reflexes
☐	☐	☐	**Acute flaccid paralysis**
☐	☐	☐	**Altered mental status**
☐	☐	☐	Ataxia
☐	☐	☐	Limb weakness (documented by HCP)
☐	☐	☐	Nerve palsies
☐	☐	☐	Parkinsonism or cogwheel rigidity
☐	☐	☐	Sensory deficit
☐	☐	☐	**Seizure new with disease**
☐	☐	☐	**Encephalitis**
☐	☐	☐	**Meningitis**
☐	☐	☐	Myelitis
☐	☐	☐	Guillain-Barre syndrome
☐	☐	☐	Other neuroinvasive _____

Y N Unk
☐ ☐ ☐ Jaundice or hepatitis
☐ ☐ ☐ Lymphadenopathy
☐ ☐ ☐ Paralysis or weakness
☐ ☐ ☐ Tremors or hand shakes
☐ ☐ ☐ Coma
☐ ☐ ☐ Multiple organ failure
☐ ☐ ☐ Any complication _____
☐ ☐ ☐ More likely clinical explanation for the illness Specify _____
☐ ☐ ☐ Previous flavivirus infection (e.g., dengue, SLE) _____

Predisposing Conditions

Y N Unk
☐ ☐ ☐ Alcoholism
☐ ☐ ☐ Blood pressure medication at time of onset
☐ ☐ ☐ Bone marrow transplant
☐ ☐ ☐ Chronic heart disease
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Chronic liver disease
☐ ☐ ☐ Chronic obstructive lung disease
☐ ☐ ☐ Congestive heart failure (pre-existing)
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ Heart attack
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Immunosuppressive therapy or condition, or disease _____
☐ ☐ ☐ Organ transplant
☐ ☐ ☐ Sickle cell disease
☐ ☐ ☐ Stroke
☐ ☐ ☐ Thyroid disease

Y N Unk
☐ ☐ ☐ Current prescriptions or treatment
☐ ☐ ☐ CAD meds at time of onset
☐ ☐ ☐ Chemotherapy at time of onset
☐ ☐ ☐ CHF medications at time of onset
☐ ☐ ☐ Hemodialysis at time of onset
☐ ☐ ☐ Insulin or other diabetes treatment at time of onset
☐ ☐ ☐ Oral or injected steroids at time of onset
☐ ☐ ☐ Other cancer medications at time of onset
☐ ☐ ☐ Other kidney medications at time of onset

Hospitalization

Y N Unk
☐ ☐ ☐ **Hospitalized at least overnight for this illness** Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Mechanical ventilation or intubation required
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk
☐ ☐ ☐ **Died of this illness** Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition

Pregnancy

Pregnancy status at time of symptom onset
☐ Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
OB name, phone, address _____
Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
☐ Postpartum (Estimated) delivery date ___/___/___
OB name, phone, address _____
Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
☐ Neither pregnant nor postpartum ☐ Unk

Vaccination

Y N Unk

☐ ☐ ☐ Japanese encephalitis or yellow fever vaccination

Vaccine information available ☐ Yes ☐ No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Clinical testing

Y N Unk

☐ ☐ ☐ CSF obtained

Glucose _____ Percent lymphocytes _____ Percent neutrophils _____

Protein _____ Red blood cells _____ While blood cells _____

☐ ☐ ☐ Pleocytosis (CSF)

RISK AND RESPONSE (Ask about exposures 2-14 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____

☐ ☐ ☐ **In area with mosquito activity or remember bite** Date ___/___/___

Location of exposure ☐ Multiple exposures ☐ Other country ☐ Other state ☐ Unk ☐ WA county _____

Specify location _____

☐ ☐ ☐ Blood transfusion or blood products (e.g., IG, factor concentrates) recipient Date ___/___/___

☐ ☐ ☐ Organ or tissue transplant recipient Date ___/___/___

☐ ☐ ☐ (Potential) Occupational exposure

☐ ☐ ☐ Lab worker

☐ ☐ ☐ Other Occupation _____

Infant Only

☐ ☐ ☐ Birth mother had febrile illness

☐ ☐ ☐ Breast fed

☐ ☐ ☐ Infected in utero

Exposure and Transmission Summary

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____

☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Vectorborne ☐ Blood products ☐ Unk ☐ Other _____

Describe _____

Exposure summary

Public Health Issues

Y N Unk

☐ ☐ ☐ **Did case donate blood products in the 30 days before symptom onset Date** ___/___/___

Agency/location _____ **Type of donation** _____

☐ ☐ ☐ **Did case donate organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis**

Date ___/___/___

Agency/location _____ **Type of donation** _____

Public Health Interventions/Actions

Y	N	Unk	
☐	☐	☐	Breastfeeding education provided
☐	☐	☐	Notified blood or tissue bank (if recent donation)
☐	☐	☐	**Mosquito control district notified** **Agency notified** _____ **Date** ___/___/___
☐	☐	☐	Letter sent Date ___/___/___ Batch date ___/___/___
☐	☐	☐	Any other public health action _____

NOTES

LAB RESULTS

Lab report information
Lab report reviewed – LHJ ☐
WDRS user-entered lab report note

Submitter _____
Performing lab for entire report _____
Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date ___/___/___ Specimen received date ___/___/___
WDRS specimen type _____
WDRS specimen source site _____
WDRS specimen reject reason _____

Test performed and result
WDRS test performed _____
WDRS test result, coded _____
WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____
WDRS unit of measure _____
Test method _____
WDRS interpretation code _____
Test result – Other, specify _____
WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
Upload document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____

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