West Nile Virus Disease

County

Case name (last, first) ______
Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other 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
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status
☐ In progress
☐ Complete
☐ Complete – not reportable to DOH
☐ Unable to complete Reason ______

Investigation start date ___/___/___
Investigation complete date ___/___/___
Case complete date ___/___/___

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

DEMOGRAPHICS

Age at symptom onset ______ ☐ Years ☐ Months
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other ______
Primary language ______
Interpreter needed ☐ Yes ☐ No ☐ Unk
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 ______

REPORT SOURCE

Initial report source ______
LHJ ______
Reporter organization ______
Reporter name ______
Reporter phone ______

All reporting sources (list all that apply)
______
______
______

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 ______

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 ______
☐ ☐ ☐ **Chills or rigors**
☐ ☐ ☐ Rash
☐ ☐ ☐ Headache

Case Name ________________________________ LHJ Case ID ________________________________

Y N Unk
- ☐ ☐ ☐ 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)

Y N Unk
- ☐ ☐ ☐ 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 ____________________________