



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 _____ LHM Case ID (optional) _____

LHM 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 _____ LHM _____

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 child's) 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

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 _____°F
 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:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> 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 _____ Submitter _____
Lab report reviewed – LHJ Performing lab for entire report _____
 WDRS user-entered lab report note _____ 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 _____ Ordering facility _____
 WDRS ordering provider _____ WDRS ordering facility name _____

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