

West Nile Virus Initial Case and Laboratory Submission Report
Hawaii Department of Health Disease Investigations Branch
 808-586-4586 (phone) • 808-586-4595 (fax) • 808-566-5049 (after-hours: Oahu)
 800-360-2575 (after-hours: Neighbor Islands)

Date of Report: ___/___/___

PATIENT INFORMATION

Last name _____ First Name _____ MI _____
 Date of Birth ___/___/___ (if not available, Age ___ years/ months/ weeks)
 Sex: Male Female (pregnant: Yes No Unknown)
 Address _____ City _____ Zip _____ Island _____
 Telephone -H (____)____-____ W (____)____-____ Occupation: _____
 Race: _____ Hispanic: Yes No
 Status: Resident Tourist (date of arrival: ___/___/___) Military Military Dependent

CONTACT PERSON (Attending physician, Infection control professional)

Last name _____ First name _____ Title (ICP, Resident, Attending) _____
 Agency _____ City _____ Phone (____)____-____

CLINICAL INFORMATION

Current diagnosis: West Nile fever Encephalitis Meningitis Other (specify _____)

Hospitalized? Yes No Hospital Name _____

Medical record # _____ Date of admission ___/___/___ Date of discharge/transfer ___/___/___

Date of first symptoms ___/___/___

Fever ($\geq 38^{\circ}\text{C}$ or 100°F)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Muscle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other	_____

Date of first *neurologic* symptoms ___/___/___

Stiff neck/Meningeal signs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Altered mental status	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

SPECIMENS BEING SUBMITTED TO HAWAII DOH FOR WEST NILE TESTING

Specimen #	Type (specify serum or CSF) 1 cc should be collected	Date of collection	For SLD use only
1.			
2.			

Did patient donate blood in the two weeks prior to illness onset? Yes No Unknown

Date of donation: ___/___/___ (or approximate date if exact date unknown)

Blood collection facility: _____

Patient's social security number: _____ - _____ - _____

<u>RISK FACTOR INFORMATION</u> (during 1 month before onset)	Location (if mainland, specify which states)	Dates
Travel outside <u>country</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	_____
Travel outside <u>Hawaii</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	_____
Travel to another <u>island</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	_____
<u>Mosquito contact</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	_____
Received <u>blood product</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	_____

<u>VACCINATION INFORMATION</u> (Has patient <u>ever</u> received any of the following vaccines?)	Dates
Yellow fever (YF) vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
Japanese encephalitis (JE) vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
Central European encephalitis (CEF) vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____

<u>ANTIVIRAL TREATMENT</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, list below.	Date started
1. _____	_____	_____
2. _____	_____	_____

LABORATORY INFORMATION / TEST RESULTS ALREADY ACQUIRED

CSF (specify units) Date ___/___/___ Abnormal? Yes No Unknown
 Glu _____ Prot _____ RBC _____ WBC _____ Diff: Segs% _____ Lymphs% _____
 Gram stain _____ Bacterial Culture _____ Fungal / Parasitic tests _____
 Viral test results (Culture/ Serology / PCR) _____

CBC (specify units) Date ___/___/___
 WBC _____ Diff: Segs% _____ Lymphs% _____ Platelets _____ Hematocrit _____
 Other tests:

OUTCOME Recovered Still ill Died (date of death ___/___/___) Unknown

Please fax this form to the Disease Investigations Branch (808-586-4595)

Specimens should be sent to:
Ms. Rebecca Sciulli
State Laboratories Division
Hawaii Department of Health
2725 Waimano Home Road
Pearl City, HI 96782