

**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:  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 $100^{\circ}\text{F}$ )	<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: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**RISK FACTOR INFORMATION** (during 1 month before onset)      **Location**      **Dates**

Travel outside country?       Yes    No    Unknown      \_\_\_\_\_      \_\_\_\_\_

Travel outside Hawaii?       Yes    No    Unknown      \_\_\_\_\_      \_\_\_\_\_

Travel to another island?       Yes    No    Unknown      \_\_\_\_\_      \_\_\_\_\_

Mosquito contact?       Yes    No    Unknown      \_\_\_\_\_      \_\_\_\_\_

Received blood product?       Yes    No    Unknown      \_\_\_\_\_      \_\_\_\_\_

**VACCINATION INFORMATION** (Has patient ever received any of the following vaccines?)      **Dates**

Yellow fever (YF) vaccine?       Yes    No    Unknown      \_\_\_\_\_

Japanese encephalitis (JE) vaccine?       Yes    No    Unknown      \_\_\_\_\_

Central European encephalitis (CEF) vaccine?       Yes    No    Unknown      \_\_\_\_\_

**ANTIVIRAL TREATMENT**       Yes    No    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**