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 (≥ 38°C or 100°F)	☐ Yes ☐ No ☐ Unknown	Muscle pain	☐ Yes ☐ No ☐ Unknown
Headache	☐ Yes ☐ No ☐ Unknown	Joint pain	☐ Yes ☐ No ☐ Unknown
Rash	☐ Yes ☐ No ☐ Unknown	Fatigue	☐ Yes ☐ No ☐ Unknown
Nausea	☐ Yes ☐ No ☐ Unknown	Chills	☐ Yes ☐ No ☐ Unknown
Vomiting	☐ Yes ☐ No ☐ Unknown	Other _____	

Date of first *neurologic* symptoms ____/____/____

Stiff neck/Meningeal signs	☐ Yes ☐ No ☐ Unknown	Seizures	☐ Yes ☐ No ☐ Unknown
Altered mental status	☐ Yes ☐ No ☐ Unknown	Muscle weakness	☐ Yes ☐ No ☐ 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