

West Nile Viral Illness Reporting Form

PATIENT INFORMATION			
Name:			DOB:
Age:	Sex: ~ M ~ F	Race: ~ White ~ Black ~ American Indian ~ Asian ~ Hispanic ~ Unk	
Address:			Phone:
City:		County:	Zip:

CLINICAL INFORMATION		
Date of Illness Onset:	Neuro-invasive Illness: ~ Yes ~ No ~ Unk	Febrile Illness: ~ Yes ~ No ~ Unk
Hospitalized: ~ Yes ~ No	Encephalitis: ~ Yes ~ No ~ Unk	Fever (\$38EC or 100EF): ~ Yes ~ No ~ Unk
Hospital Name:	Meningitis: ~ Yes ~ No ~ Unk	Muscle Weakness: ~ Yes ~ No ~ Unk
Date of Admission:	Stiff neck/Meningeal signs: ~ Yes ~ No ~ Unk	Headache: ~ Yes ~ No ~ Unk
Discharge Date:	Seizures: ~ Yes ~ No ~ Unk	Rash: ~ Yes ~ No ~ Unk
Health Care Provider:	Altered Mental Status: ~ Yes ~ No ~ Unk	Muscle pain: ~ Yes ~ No ~ Unk
Phone:	Other neurological signs: ~ Yes ~ No ~ Unk	Muscle Weakness: ~ Yes ~ No ~ Unk
Date Reported to Local Health Department::	Outcome: ~ Recovered ~ Still ill ~ Deceased ~ Unk	
Date of Death:		

LABORATORY INFORMATION	
Date Lab Specimen Collected:	Testing Laboratory:
Specimen Source: ~ Blood ~ CSF ~ Other (<i>List below</i>)	IgM: ~ pos ~ neg ~ equiv IgG: ~ pos ~ neg ~ equiv <i>(Please attach lab report(s) if available.)</i>

OUT OF STATE TRAVEL HISTORY		
Travel outside Montana 14 days prior to illness onset? ~ Yes ~ No ~ Unk	Location(s):	Dates:

COUNTY HEALTH DEPARTMENT USE ONLY	
~ New Case ~ Update of prior report	Out of Jurisdiction Case. Case was: ~ Referred to DPHHS ~ Referred to County of Residence
Comments:	
Local Health Department Reviewer:	Date:

Additional Questions to Assess Underlying Medical Conditions and Medication Use

1. Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?

- | | | | |
|--|------------------------------|-----------------------------|----------------------------------|
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| High blood pressure (hypertension) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Heart attack (myocardial infarction) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Angina or coronary artery disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Congestive heart failure (CHF) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Chronic liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Kidney disease or failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Bone marrow transplant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Solid organ transplant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

If yes: What organ was transplanted?: _____

What year was the transplant?: _____

- | | | | |
|--------|------------------------------|-----------------------------|----------------------------------|
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
|--------|------------------------------|-----------------------------|----------------------------------|

If yes: What type(s)?: _____

What year were you diagnosed?: _____

Are you currently being treated for cancer?: Yes No Unknown

2. Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection? Yes No Unknown

If yes: What condition(s)?: _____

3. At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?

- | | | | |
|--|------------------------------|-----------------------------|----------------------------------|
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Other treatments for cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Hemodialysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Other treatments for kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Oral or injected steroids | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Inhaled steroids | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Insulin or other medications to treat diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications to treat high blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications to treat coronary artery disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications to treat congestive heart failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications that suppress the immune system | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

4. Which of the following sources provided the information above?

- | | | | | | |
|----------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| Patient | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Family member/friend | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Provider | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medical record | <input type="checkbox"/> Yes | <input type="checkbox"/> No |