

West Nile Virus Human Surveillance Patient Report

Complete form and fax to: Niagara Region Public Health Infectious Disease Program

Hospital Site: _____ Reported By: _____	
Hospital MD: _____ Family MD: _____	
Patient Name: _____	
Date of Birth (yy/mm/dd): ____/____/____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient Address: _____ City: _____	
Province: _____ Postal Code: _____ Patient Phone Number: _____	
Symptom onset (yy/mm/dd): _____ Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Admit date (yy/mm/dd): _____ Discharge Date (yy/mm/dd): _____	
Diagnosis: _____ Date of Death (yy/mm/dd): _____	
Check all the conditions identified:	
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No	Fluctuating Level of Consciousness <input type="checkbox"/> Yes <input type="checkbox"/> No
Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Guillain-Barre <input type="checkbox"/> Yes <input type="checkbox"/> No	Acute Flaccid Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Poliomyelitis-like syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> _____
Has the patient received Yellow Fever vaccine in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Has the patient received Japanese Encephalitis Virus vaccine in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
In the previous <u>three weeks</u> was there:	
Camping/cottage visit in Ontario? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, when? (yy/mm/dd) _____
Travel to other provinces or countries? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, when? (yy/mm/dd) _____
Dates of travel: From (yy/mm/dd) _____ To: (yy/mm/dd) _____	
Did the patient reside in the Southwest/Southcentral area of Ontario in 2007? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments: _____	
In the previous <u>8 weeks</u>, did the patient give or receive blood/plasma/tissue/organ? <input type="checkbox"/> Yes <input type="checkbox"/> No (yy/mm/dd)	
Laboratory	
1 st serum taken? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, when? (yy/mm/dd) _____
2 nd serum taken? (if required) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, when? (yy/mm/dd) _____
Was CSF examined? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, when? (yy/mm/dd) _____
In hospital lab results? WBC cells: _____ X 10L RBC: _____ X 10L	
WBC Differential: Neutrophils: _____ Lymphocytes: _____ Monocytes: _____ Other: _____	
CSF Protein: _____ g/L CSF Glucose: _____ mmol/L	
Was CSF sent for WNV Testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If the patient died, were pathology specimens tested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Laboratory Results (to be completed by Public Health)	
IgM capture Elisa (sera &/orCSF) <input type="checkbox"/> Pos <input type="checkbox"/> Neg	HI Seroconversion <input type="checkbox"/> Yes <input type="checkbox"/> No
HI Single Titres ≥ 1:320 <input type="checkbox"/> Yes <input type="checkbox"/> No	(4-fold or >rise in titre paired sera)
PRNT Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No	
Public Health Laboratory Number: _____	

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