West Nile Virus Report Form
NM Record Number:

	When completed, fax or mail this form to: Epidemiology and Response Division, NMDOH 1190 St. Francis Drive, N1350 P.O Box 26110 Santa Fe, NM 87502-6110 Phone: (505) 827-0006 Fax: (505) 827-0013 (Form may be saved to the X Drive. Follow guidelines for saving to X drive.)	For District Office use only: ☐Reviewed ☐Sent to EPI	For Office of EPI use only: Case Confirmation ☐Confirmed ☐Probable ☐Suspect ☐File only, do not enter

Date received by Epidemiology and Response Division:

Interviewer: (print)	Phone:	Date completed:

EPI Contact person:	Phone Number EPI Contact:

Patient Name: (last, first)

DOB:	**Sex:** ☐ **Male** ☐ **Female**	**Patient's Age:** **Years** **Months**
Phone Number: (Home)	**Phone Number: (Work)**	**Phone Number: (Cell)**

Address (street):	**Race:** ☐**Am Indian/Alaskan native** ☐**Asian/Pacific Islander** ☐**White** ☐**Black** ☐**Unknown**	**Ethnicity:** ☐**Hispanic** ☐**Non-Hispanic**

City:	**County:**	**State:**	**ZIP:**

Parent/Spouse/Guardian Name: (last, first)

Physician/Provider name (last, first)	Phone Number (Physician/Provider)

Laboratory Results:

Blood or Serum		**Cerebral Spinal Fluid**	
Date:	**CBC results**	Date:	**CSF results**
White Blood Cell Count		Opening Pressure	
Differential		Red Blood Cell Count	
Hematocrit		White Blood Cell Count	
Platelets		Differential	
		Protein	
		Glucose	
		PCR results	
ELISA IgM	☐Positive ☐ Negative ☐Equivocal	ELISA IgM	☐Positive ☐ Negative ☐Equivocal
ELISA IgG	☐Positive ☐ Negative ☐Equivocal	ELISA IgG	☐Positive ☐ Negative ☐Equivocal
Name of Laboratory		Name of Laboratory	

Symptoms and Outcome: (check all that apply)

Symptomatic? ☐yes ☐ no ☐unk	Date of onset of first symptom(s):	Duration of illness: Days
Headache ☐yes ☐ no ☐unk	Fever ☐yes ☐ no ☐unk Temp	Weakness ☐yes ☐ no ☐unk
Rash ☐yes ☐ no ☐unk	Mental status change ☐yes ☐ no ☐unk	Myalgias ☐yes ☐ no ☐unk
Arthralgias ☐yes ☐ no ☐unk	Encephalitis ☐yes ☐ no ☐unk	Meningitis ☐yes ☐ no ☐unk

Patient's Name	DOB	
Flaccid paralysis ☐yes ☐ no ☐unk	Diarrhea ☐yes ☐ no ☐unk	Vomiting ☐yes ☐ no ☐unk
Hospitalized ☐yes ☐ no ☐unk	Name of hospital	
Date of Admit	Date of discharge	☐survived ☐died
Date of death	Autopsy performed ☐ yes☐ no ☐unk	Date of autopsy

Risk factors for Infection:	
Does the patient report mosquito bites in the two weeks before illness? ☐yes ☐ no ☐unk	If yes, where and when? Where Date Where Date
Did the patient travel outside his/her home state or out of the country in the two weeks before illness began? ☐yes ☐ no ☐unk	City, County, State From To City, County, State From To
Did the patient receive any blood products in the month before illness began? ☐yes ☐ no ☐unk	Date received Product type
Is the patient pregnant? ☐yes ☐ no ☐unk	Due Date or Date of Delivery

Comments: (100 characters per line)

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?

Condition			
Diabetes	☐ Yes	☐ No	☐ Unknown
High blood pressure (hypertension)	☐ Yes	☐ No	☐ Unknown
Heart attack (myocardial infarction)	☐ Yes	☐ No	☐ Unknown
Angina or coronary artery disease	☐ Yes	☐ No	☐ Unknown
Congestive heart failure (CHF)	☐ Yes	☐ No	☐ Unknown
Stroke	☐ Yes	☐ No	☐ Unknown
Chronic obstructive pulmonary disease (COPD)	☐ Yes	☐ No	☐ Unknown
Chronic liver disease	☐ Yes	☐ No	☐ Unknown
Kidney failure or chronic kidney disease	☐ Yes	☐ No	☐ Unknown
Alcoholism	☐ Yes	☐ No	☐ Unknown
Bone marrow transplant	☐ Yes	☐ No	☐ Unknown
Solid organ transplant	☐ Yes	☐ No	☐ Unknown

If yes: What organ was transplanted?: ____

What year was the transplant?: ____

Cancer ☐ Yes ☐ No ☐ 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?

Medication or treatment			
Chemotherapy	☐ Yes	☐ No	☐ Unknown
Other treatments for cancer	☐ Yes	☐ No	☐ Unknown
Hemodialysis	☐ Yes	☐ No	☐ Unknown
Other treatments for kidney disease	☐ Yes	☐ No	☐ Unknown
Oral or injected steroids (not inhaled or topical)	☐ Yes	☐ No	☐ Unknown
Insulin or other medications to treat diabetes	☐ Yes	☐ No	☐ Unknown
Medications to treat high blood pressure	☐ Yes	☐ No	☐ Unknown
Medications to treat coronary artery disease	☐ Yes	☐ No	☐ Unknown
Medications to treat congestive heart failure	☐ Yes	☐ No	☐ Unknown
Medications that suppress the immune system	☐ Yes	☐ No	☐ Unknown

4. Which of the following sources provided the information above? **(check all that apply)**

Patient	☐ Yes	☐ No	Family member/friend	☐ Yes	☐ No
Provider	☐ Yes	☐ No	Medical record	☐ Yes	☐ No