

## West Nile Viral Illness Reporting Form

PATIENT INFORMATION			
Name:			DOB:
Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Unk	
Address:			Phone:
City:	County:	Zip:	

CLINICAL INFORMATION		
Date of Illness Onset:	<b>Neuro-invasive Illness:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<b>Febrile Illness:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Encephalitis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fever ( <input type="checkbox"/> 88°C or 100°F): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hospital Name:	Meningitis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Muscle Weakness: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Date of Admission:	Stiff neck/Meningeal signs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Headache: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Discharge Date:	Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Health Care Provider:	Altered Mental Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Muscle pain: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Phone:	Other neurological signs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Muscle Weakness: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Date Reported to Local Health Department::	<b>Outcome:</b> <input type="checkbox"/> Recovered <input type="checkbox"/> Still ill <input type="checkbox"/> Deceased <input type="checkbox"/> Unk	
Date of Death:		

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

OUT OF STATE TRAVEL HISTORY		
Travel outside Montana 14 days prior to illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Location(s):	Dates:

COUNTY HEALTH DEPARTMENT USE ONLY	
<input type="checkbox"/> New Case <input type="checkbox"/> Update of prior report	Out of Jurisdiction Case. Case was: <input type="checkbox"/> Referred to DPHHS <input type="checkbox"/> Referred to County of Residence
Comments:	
Local Health Department Reviewer:	Date: