Viral CNS Infection Case Investigation

West Nile Virus

Michigan Department of Community Health
Communicable Disease and Immunization Division

Investigation Information

Investigation ID	**Part of an outbreak?** *Yes No Unknown*	**Outbreak Name**	**Referral Date** mm/dd/yyyy

Investigation Status *New Active Completed Superceded Cancelled*	**Case Status** *Confirmed Not a Case Probable Suspect Unknown*

Patient Status *Inpatient Outpatient Died*	**Patient Status Date** mm/dd/yyyy	**Diagnosis Date** mm/dd/yyyy	**Onset Date** mm/dd/yyyy

Patient Information

Patient ID	**First**	**Last**	**Middle**

Street Address

City	**County**	**State**	**Zip**

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**

Parent/Guardian (required if under 18)

First	**Last**	**Middle**

Demographics

Sex *Male Female Unknown*	**Date of Birth** mm/dd/yyyy	**Age**	**Age Units** *Days Months Years*

Race
Caucasian African American American Indian/Alaska Native Hawaiian/Pacific Islander
*Asian Unknown Other (Specify)*______________________

Ethnicity *Hispanic/Latino Non-Hispanic/Latino Unknown*	**Worksites/School**	**Occupations/Grade**

Referral Information

Person Providing Referral

First	**Last**	**Phone** ###-###-####	**Ext.**	**Email**

Primary Physician

First	**Last**	**Phone** ###-###-####	**Ext.**	**Email**

Street Address

City	**County**	**State**	**Zip**

Hospital Information

Patient Hospitalized	**Hospital**	**Hospital City**	**Hospital Record No.**
Yes No Unknown			

Admission Date	**Discharge Date**	**Days Hospitalized**	**Patient Died**
mm/dd/yyyy	mm/dd/yyyy		*Yes No Unknown*

Clinical Information

Clinical Information from Attending Physician:
(Check all that apply)

Confusion/memory loss *Upper respiratory symptoms* *Headache* *Sensory abnormalities*
Rash *Stiff neck/back* *Convulsion/tremor* *Herpes sores (within 1 month)*
Lethargy/somnolence *Photophobia* *Stupor/coma*

Fever?	**If yes, specify highest temperature:**	**Scale**
Yes No Unknown		*F C*

Muscle weakness/paralysis?	**If yes, which muscles?**	**Other Symptoms?**	**If yes, please specify:**
Yes No Unknown		*Yes No Unknown*	

Other relevant clinical information:

Laboratory Information

Specimen Type	Date Specimen Obtained	Test Type	Test Result
	mm/dd/yyyy		
Acute Serum			
Convalescent Serum			
Feces			
CSF			

Lumbar puncture/CSF examination:	**If No, how was Diagnosis made?**
Yes No Unknown	

If Yes:

CSF white blood count:	**Differential:**

Other CSF Results

Glucose:	**Protein:**	**Bacterial antigens:**

Epidemiologic Information

Within ONE MONTH of the onset of symptoms in the patient:

Does the patient know of anyone else with a similar illness?	**Was the patient exposed to anyone with a respiratory, gastro-intestinal, or rash illness?**
Yes No Unknown	*Yes No Unknown*

For any Yes answers to the above questions, please provide all relevant details:

Name	Address	Phone #
		###-###-####

Epidemiologic Information cont.

Was the patient pregnant or nursing?

Yes *No* *Unknown*

Has the patient received an organ donation/blood transfusion?

Yes *No* *Unknown*

What was the patient's Occupation during the last month?

Was there heavy exposure(s) to biting insects?

Yes *No* *Unknown*

What was the patient doing when they were most likely exposed to mosquito bites?

During the last month, did the patient regularly wear mosquito repellant when outdoors?

Yes *No* *Unknown*

For any Yes answers to the above questions, please provide all relevant details:

Location	Date	Comments
	mm/dd/yyyy	

Travel Information

Did the patient travel outside of Michigan?

Yes *No* *Unknown*

If yes, please provide all relevant details:

To Date	From Date	Location	Comments
mm/dd/yyyy	mm/dd/yyyy		

Has the patient ever received a vaccination for a flavivirus (Japanese encephalitis or Yellow Fever)?

Yes *No* *Unknown*

Home Drinking Water:

Municipal *Well* *Bottled* *Other*____________________

Home Sewage System:

Septic Tank *Municipal* *Other*____________________

Lab Results

Report Date	Test Name	Test Result	Specimen	Collection Date
mm/dd/yyyy		Code/Alternate Code/Text Result/Numeric Result		mm/dd/yyyy

Other Information

Local 1	Local 2

Name of Person interviewed	Relationship to patient	Date of interview mm/dd/yyyy

Submitted by:	Date mm/dd/yyyy	Health Department	Phone Number ###-###-####	Ext.

Comments or Additional Information