

Report form: Suspected West Nile virus infection

Version 4.1 May 2005



Form sent by _____ Tel _____ Date ____/____/____
Laboratory _____ Clinician _____

CASE IDENTIFICATION

- 1 **First name:** _____
- 2 **Surname:** _____
- 3 **Sex:** Male Female
- 4 **Date of birth:** ____/____/____
- 5 **Hospital:** _____
- 6 **Date of admission:** ____/____/____
- 7 **Has case been in the USA since 1998?** Yes No
- 8 **Has case returned from outside the UK in the previous three weeks before onset?** Yes, _____ (please state) No

CLINICAL INFORMATION

- 9 **Has the case ever had the following vaccinations? (please tick all that apply)**
- | | | | |
|-------------------------|------------------------------|-----------------------------|----------------------------------|
| Yellow fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> unknown |
| Tick borne encephalitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> unknown |
| Japanese encephalitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> unknown |
- 10 **Date of onset of symptoms** ____/____/____
- 11 **Duration of symptoms** _____
- 12 **Clinical features:**
- Fever
 - Rash
 - Lymphadenopathy
 - Myalgia / Arthralgia
 - Headache/ Fatigue
 - Photophobia
 - Nausea / Vomiting
- Other neurological features:**
- Tremor
 - Parkinsonism
 - Other (please specify) _____
- 13 **Clinical diagnosis:** (for surveillance definitions see protocol)
- Encephalitis / Meningoencephalitis
 - Meningitis
 - Acute Flaccid Paralysis
 - Other, please state: _____
- 14 **Case died?** Yes No

MICROBIOLOGICAL INFORMATION

- 15 **Tests done to exclude bacterial cause:**
- | | | | |
|------------------------------|-------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> CSF | <input type="checkbox"/> Gram stain | <input type="checkbox"/> Blood | <input type="checkbox"/> Gram stain |
| | <input type="checkbox"/> Culture | | <input type="checkbox"/> Culture |
| | <input type="checkbox"/> PCR | | <input type="checkbox"/> PCR |
- 16 **Tests done to exclude enterovirus / herpes:**
- | | | | |
|------------------------------|--|--------------------------------|--|
| <input type="checkbox"/> CSF | <input type="checkbox"/> Antibody test | <input type="checkbox"/> Blood | <input type="checkbox"/> Virus isolation |
| | <input type="checkbox"/> Virus isolation | | <input type="checkbox"/> PCR |
| | <input type="checkbox"/> PCR | | <input type="checkbox"/> Serology |
- 17 **Samples submitted to HPA CEPR, Special Pathogens Reference Unit (SPRU)**
- | | |
|--|--|
| <input type="checkbox"/> CSF, ____ tubes | <input type="checkbox"/> Serum, ____ tubes |
|--|--|

Thank you for your co-operation.

Please return form to: Dr Neil Irvine, Communicable Disease Surveillance Centre, McBrien Building, Belfast City Hospital, Lisburn Road, Belfast BT9 7AB. Email: neil.irvine@hpa.org.uk Tel: 028 9026 3765 Fax: 028 9026 3511