BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Human Case Report
West Nile Virus Infection

Fax completed reports to 604-707-2516 Attn: Marsha Taylor

Provincial Health Services Authority
Province-wide solutions. Better health.

Instructions:
To complete this form, interview both the *patient and his/her physician*:

- Complete section A using symptom info from section D and F and advice of local MHO
- Complete sections B, C, D, E with the patient
- Complete section F with the patient's physician
- Fax completed questionnaires to BCCDC: 604-707-2516, attn: Marsha Taylor
- **In an outbreak, complete page 1 immediately and provide pages 2-4 as an update when able**

Report Date: _____/_____/_____ (dd/mm/yyyy)
☐ This is a new case report
☐ This is an update

Person Reporting:
Name ________________________________
Health Unit: ___________________________
Tel: _______-_________-_________

SECTION A. CASE CLASSIFICATION

Please complete Section A using symptom info from section D and F and the advice of the local MHO. Refer to BC WNV Case Definitions posted at www.bccdc.ca. If neurological symptoms are reported in sections D or F of this questionnaire, please report the case as WNNS. *NB. Please report probable or confirmed WNV cases in iPHIS*

	Suspect Case	**Probable Case**	**Confirmed Case**
West Nile virus Neurological Syndromes (WNNS)			
West Nile virus non-neurologic syndrome (WN-Non-NS) Was fever present? ☐ No ☐ Yes	(shaded)		
West Nile virus Asymptomatic Infection (WNAI)	(shaded)		

Travel-acquired from a known endemic area? ☐ No ☐ Yes ☐ Unknown
If yes: AB SK MN ON QC NS PEI NB NF YK NWT BC-Endemic:______________
USA (State): ________________ Other: _____________________

SECTION B. PATIENT INFORMATION

Last name ____________________________ First name ___________________ Middle Initial: ___
Date of Birth _____/_____/_____ (dd/mm/yyyy) (if not available, Age_______ years/ months/ weeks)
Sex: ☐ Male ☐ Female Pregnant? ☐ Yes ☐ No PHN: |___|___|___|___|___|___|___|___|___|___|

Street Address ____ Apt ________
City/Town ______________________ Prov/Terr BC Postal Code: ______ ______
Tel. Home (______) ________ - ________ Work (_______) ________ - _________
Is this patient immunosuppressed or suffering from a chronic disease? ☐ No ☐ Yes ☐ Unknown
If yes, specify: ____
Does this patient have any pre-existing neurological disorders? ☐ No ☐ Yes ☐ Unknown
If yes, specify: ____
Was this patient admitted to hospital for this illness? ☐ No ☐ Yes ☐ Unknown
Hospital name___________________________________ Date of admission ___/___/___ (dd/mm/yy)
Has patient died? ☐ No ☐ Yes If yes, how did West Nile virus relate to the cause of death:
☐ Underlying cause of death ☐ WNV did not contribute to death; incidental
☐ WNV contributed, but wasn't underlying cause ☐ Unknown

Complete if only page 1 is submitted: Symptom onset date ____/____/____ (dd/mm/yy) ***OR*** ☐ Asymptomatic

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The First Nations and Inuit Health Branch, Health Canada, is very interested in collecting the following information: Are you Aboriginal? ☐Yes ☐ No ☐ Unknown
If Yes, please specify: ☐First Nations ☐ Metis ☐ Inuit
If Yes to First Nations, is primary residence on reserve? ☐Yes ☐No

SECTION C. MODE OF TRANSMISSION

Please ask the patient about *each* of the following possible modes of transmission.
In the last column of the table, please check *only one* box to indicate the most likely mode of transmission.

Mode of Transmission	Response		Details of Exposure	Choose most likely mode of transmission
Do you recall a mosquito bite in the 3 weeks before onset?	☐ No	☐ Yes	City: ________ Specific locale: ________	☐ *Note: unless other mode identified, check as default*
Is case a breast fed infant?	☐ No	☐ Yes		☐
Is case an infant infected in utero?	☐ No	☐ Yes		☐
Is this a laboratory-acquired infection?	☐ No	☐ Yes	Facility: ________	☐
Did you have direct contact with birds in the 3 weeks before onset?	☐ No	☐ Yes	Describe:	☐
Did you recently donate or receive blood, plasma or blood components?*	***Donated* in 8 weeks before onset?** ☐ No ☐ Yes	***Received* in 4 weeks before onset?** ☐ No ☐ Yes	Date: ___/___/___ (dd/mm/yyyy) Hospital/Clinic/Physician: ________ City ________ Prov/Terr ________	☐
Did you donate or receive organs or tissues in the past 8 weeks?^	***Donated* in 8 weeks before onset?** ☐ No ☐ Yes	***Received* in 8 weeks before onset?** ☐ No ☐ Yes	Date: ___/___/___ (dd/mm/yyyy) Hospital/Clinic/Physician ________ City ________ Prov/Terr ________	☐
Other mode of transmission: ________	☐ No	☐ Yes		☐

* If patient/client was a *donor* and/or *recipient* of blood/plasma/platelets or bone marrow, please notify Canadian Blood Services (24 hour call line 604-876-7219 or fax 604-879-6669).

^ If patient/client was a *donor* and or *recipient* of organs or tissues, please notify local Medical Health Officer.

SECTION D. CLINICAL INFORMATION COMPLETED WITH PATIENT

Symptom onset date ____/____/____ (dd/mm/yy) **(Please try to complete).**
OR ☐ Asymptomatic. IF ASYMPTOMATIC, SKIP TO SECTION E.

Signs and Symptoms	**Yes**	**No**	**Don't Know /Unsure**
Fever ($\geq 38^o$ or $\geq 100^oF$)	☐	☐	☐
Headache	☐	☐	☐
Muscle pain	☐	☐	☐
Joint pain	☐	☐	☐
Confusion or unusual forgetfulness	☐	☐	☐
Blurred vision or deterioration in eyesight	☐	☐	☐
Tremors	☐	☐	☐
Unusual fatigue/sleepiness	☐	☐	☐
Weakness in arms/legs	☐	☐	☐
Stiff neck	☐	☐	☐
Rash	☐	☐	☐
Enlarged glands	☐	☐	☐
Other signs/symptoms (Please specify) ______________________________	☐	☐	☐

SECTION E. TRAVEL AND RESIDENCE HISTORY
(Note: In an outbreak situation, Section E not required if case lives in an endemic area of BC i.e. 3 confirmed corvids in the LHA)

In the 3 weeks before onset of your symptoms (or before diagnosis, if asymptomatic), did you travel more than 100 km distance (1 hour drive on highway roads) from your residence? ☐Yes ☐No ☐ Don't know

Dates of travel		City/Town	Province/State	Country
From (dd/mm/yy)	To: (dd/mm/yy)			
____/____/____	____/____/____			
____/____/____	____/____/____			
____/____/____	____/____/____			
____/____/____	____/____/____			

Excluding the 3 weeks before onset of your symptoms, and in the last 10 years, have you lived or traveled to:

SE Asia	☐ Yes	☐ No	Indian subcontinent	☐ Yes	☐ No
E Asia (China, Japan, etc)	☐ Yes	☐ No	Middle East	☐ Yes	☐ No
Australia	☐ Yes	☐ No	Caribbean	☐ Yes	☐ No
Africa	☐ Yes	☐ No	USA	☐ Yes	☐ No
Mediterranean	☐ Yes	☐ No	Central/South America	☐ Yes	☐ No

Have you been immunized against: Japanese encephalitis? ☐Yes ☐ No Yellow Fever? ☐Yes ☐ No

The patient interview is complete. Please complete section F with case's physician. Check one:
☐ I have completed the physician interview by phone (see attached)
☐ I have faxed the physician the form for completion

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SECTION F: CLINICAL INFORMATION COMPLETED WITH PHYSICIAN

Case name: ___________________________________ Date of report: _____/______/______ (dd/mm/yyyy)

Physician name: ______________________________ ☐ GP ☐Specialist: ________________________

Telephone number: _____________________

Infected persons may experience neurologic symptoms ranging from mild to severe. Please check any that apply:

West Nile virus-related Syndromes	**Yes**	**No**	**Don't**
Meningitis	☐	☐	☐
Encephalitis	☐	☐	☐
Meningoencephalitis	☐	☐	☐
Acute Flaccid Paralysis. If Yes, please specify:	☐	☐	☐
Poliomyelitis-like Syndrome	☐	☐	☐
Guillain Barré-like Syndrome (GBS)	☐	☐	☐
Other (specify: ____)			
Movement disorders (e.g. tremors, myoclonus)	☐	☐	☐
Parkinsonism (e.g. cogwheel rigidity, bradykinesia, postural instability)	☐	☐	☐
Rhabdomyolysis	☐	☐	☐
Peripheral neuropathy	☐	☐	☐
Polyradiculopathy	☐	☐	☐
Optic neuritis	☐	☐	☐
Acute demyelinating encephalomyelitis (ADEM)	☐	☐	☐
Other neurologic symptoms (i.e. facial muscle weakness, occulo-motor disorders, etc):_______________________________________	☐	☐	☐

Other comments: