California Department of Public Health
Viral and Rickettsial Disease Laboratory
850 Marina Bay Parkway
Richmond, CA 94804

West Nile Virus (WNV) Infection Case Report
SUPPLEMENTAL INVESTIGATION FORM

Date Form Completed:___/___/____

Beginning in 2008, the Centers for Disease Control and Prevention (CDC) will collect surveillance data on selected underlying medical conditions and therapies that have previously been identified as risk factors for severe illness, hospitalization, and/or death among persons with WNV disease. Initial reports of WNV infections should be sent to the California Department of Public Health immediately after they have been confirmed. However, this supplemental investigation form is not time-sensitive and can be submitted at any time after a case has been reported.

Questions to Assess Underlying Medical Conditions and Medication Use

Patient Name (Last, First): _____ **DOB:**___/___/___

Clinical syndrome: ☐ Neuroinvasive disease ☐ West Nile fever ☐ Other clinical ☐ Asymptomatic infection

1. Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?

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?

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

FAX this form: (951) 358-5102 or 358-5446 for questions call Disease Control at (951) 358-5107 after hours (951) 782-2974

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