

West Nile Encephalitis Case Investigation Hospital Form - St. Louis Region

CASE INFORMATION

ID Number: _____ Date Case Was Reported: ___/___/___ Date of chart/review: _____

Name of person who reviewed chart: _____

Please Check Reason for West Nile Infection Suspicion:

- IgM-capture ELISA on CSF
 4 fold rise in IgG tier from paired acute/convalescent sera confirmed by PRNT
 Simultaneous presence of IgM and IgG antibodies in serum
 PCR isolation of DNA from CSF, blood, or tissue
 Isolation of WNV on culture of CSF, blood, or tissue
 Serum only

Date of Diagnostic Test: ___/___/___

PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (MI)

Hospital: _____ Medical Record Number: _____

Date of Admission: ___/___/___ Date of Discharge: ___/___/___

Admission Diagnoses: _____ ICD9 Code _____
 _____ ICD9 Code _____
 _____ ICD9 Code _____

Discharge Diagnoses: _____ ICD9 Code _____
 _____ ICD9 Code _____
 _____ ICD9 Code _____

Chief Complaint: _____

Date of onset of chief complaint or date patient first became ill: ___/___/___

Symptoms on Presentation

Sources of information (check all that apply):

ER note Intern H&P Resident Attending Consult Unknown

(In the event of contradictory information complete via hierarchy: Consult > Attending > Resident > Intern > ER)

Condition	Present (X)	Condition	Present (X)	Condition	Present (X)	If Ever Present (X)
Fever If yes, max temp. _____ C/F		Nausea		Altered mental status* If yes, specify:		
Headache		Diarrhea		Memory loss*		
Stiff neck		Vomiting		Tremors*		
Photophobia		Abdominal pain		Slurred speech*		
Fatigue		Poor appetite		Unconscious*		
Swollen glands (Lymphnodes)		Chest pain		Confusion*		
Joint pains		Shortness of breath				
Muscle pains		Urinary symptoms If yes, specify:				
Sore throat		Rash If yes, specify:		Muscle weakness*† If yes, which muscles: <input type="checkbox"/> Upper extremities <input type="checkbox"/> Lower extremities		
Conjunctivitis (red eyes)		Cough				
* Please note if symptoms ever developed † Describe in detail complaints of motor weakness				Seizures* If yes, specify type: <input type="checkbox"/> generalized <input type="checkbox"/> focal <input type="checkbox"/> status epilepticus		

PAST MEDICAL HISTORY

Condition	Present (X)	Other Comments	Condition	Present (X)
Hypertension			Prior viral encephalitis:	
Diabetes		If yes, specify type of diabetes: ___ IDDM ___ NIDDM	West Nile Encephalitis	
Cardiac disease		If yes, specify:	St. Louis Encephalitis	
Lung disease		If yes, specify:	Dengue Fever	
Hepatitis		If yes, specify: ___ Hep A ___ Hep B ___ Hep C ___ Other	Japanese Encephalitis	
Pancreatitis			Other flavivirus	
Seizures		If yes, specify:	Please Specify: _____	
Alcohol Abuse				
Cancer		If yes, specify: Currently on treatment:		
Asthma				
Status 1		If yes, last CD4 Count ___ Date: ___/___/___		
Other immunocompromising diseases (e.g., post marrow or solid organ transplant, on immunosuppressive drugs for cancer, or high-dose steroids)		If yes, specify:		

Has the patient ever served in the military? Yes / No / Unknown
 If Yes, during what dates? ___/___/___ to ___/___/___

Has the patient ever received a vaccination against:
 Yellow Fever: Yes / No / Unknown If Yes, Date of vaccination: ___/___/___
 Name of physician who administered the vaccine: _____ Telephone: () _____
 Japanese Encephalitis virus: Yes / No / Unknown If Yes, Date of vaccination: ___/___/___
 Name of physician who administered the vaccine: _____ Telephone: () _____
 Tick-borne Encephalitis (TBE): Yes / No / Unknown If Yes, Date of vaccination: ___/___/___
 Name of physician who administered the vaccine: _____ Telephone: () _____

PHYSICAL EXAM ON ADMISSION

Vital Signs (these should be the first taken, usually on the initial ER triage sheet)
 Temperature: _____ Resp. Rate: _____ HR: _____ B/P: _____
 Duration of fever (consecutive days since admission with T≥100.4°F / T≥38.0°C): _____ # Days
 Mental Status on presentation to the ED or as noted on admission note (Level of alertness, check one):
 Alert ___ Somnolent ___ Lethargic ___ Stuporous/obtunded ___ Comatose ___
 Describe other mental status abnormalities on presentation: _____

Symptoms at physical exam

Sources of information (check all that apply):
 ___ ER note ___ Intern H&P ___ Resident ___ Attending ___ Consult ___ Unknown
 (In the event of contradictory information complete via hierarchy: Consult > Attending > Resident > Intern > ER)

Condition	Present (X)	Other Comments	Condition	Other Comments	Present (X)
Stiff neck			Other		
Brudzinski			Lymphadenopathy		
Kernig			Skin*	If abnormal, specify type of rash & location:	
Photophobia			Abdomen*	If abnormal, specify type & location:	
Conjunctivitis			Heart exam*	If abnormal, specify type & location:	

*Check if abnormal

Other significant positive findings (describe): _____

EARLIEST AVAILABLE LABORATORY STUDIES

Test	Results	Other Comments
Urinalysis If yes, Date: ___/___/___	General: _____ Color: _____ WBC's: _____ Protein: _____	
CBC If yes, Date: ___/___/___	HGB: _____ HCT: _____ Platelets: _____ Total WBC: _____ % Gran: _____ % Bands: _____ % Lymph: _____ % Monos: _____ % Eosinophil _____ Absolute Gran: _____	
T cell studies If yes, Date: ___/___/___	CD4: _____ CD8: _____ % CD4: _____	
Chemistry If yes, Date: ___/___/___	Na: _____ K: _____ CL: _____ CO2: _____ BUN: _____ Cr: _____ Glucose: _____	
BhCG If yes, Date: ___/___/___		
CPK 1st Date: ___/___/___ 2nd Date: ___/___/___ 3rd Date: ___/___/___	Total: _____ MB: _____ Index: _____ Total: _____ MB: _____ Index: _____ Total: _____ MB: _____ Index: _____	
LFT's If yes, Date: ___/___/___	AST: _____ ALT: _____ T.bili: _____ Indirect bili: _____ Alk phos: _____ GGT: _____	
Amylase If yes, Date: ___/___/___	Amylase _____	
Lipase If yes, Date: ___/___/___	Lipase _____	
LDH If yes, Date: ___/___/___	LDH _____	
Spinal tap done? If yes, 1st CSF - Date: ___/___/___ Opening pressure: _____ cm H ₂ O	Differential % Neutrophils: _____ % Segs: _____ % Lymphs: _____ Protein: _____ WBC count: _____ Gram stain: _____ If positive, specify: _____ Bacterial culture: _____ If positive, specify: _____ Herpes PCR: _____ Enterovirus PCR: _____ Other: _____	
If yes, 2nd CSF - Date: ___/___/___ Opening pressure: _____ cm H ₂ O	Differential % Neutrophils: _____ % Segs: _____ % Lymphs: _____ Protein: _____ WBC count: _____ Gram stain: _____ If positive, specify: _____ Bacterial culture: _____ If positive, specify: _____ Herpes PCR: _____ Enterovirus PCR: _____ Other: _____	

DIAGNOSTIC RESULTS

Diagnostic Test	Positive (X)	Test Date
IgM-capture ELISA on CSF		___/___/___
4 fold rise in IgG titer from paired acute/convalescent sera confirmed by PRNT		___/___/___
Simultaneous presence of IgM and IgG antibodies in serum		___/___/___
PCR Detection of DNA from CSF, blood, or tissue		___/___/___
Isolation of WNV on culture of CSF, blood, or tissue		___/___/___
Serum Only		___/___/___

RADIOLOGICAL AND DIAGNOSTIC STUDIES

(Final reports ONLY. Please write in all findings)

EKG (_ / _ / _):

CXR (_ / _ / _):

EMG (_ / _ / _):

MRI of head (_ / _ / _):

CT of head (_ / _ / _):

HOSPITAL COURSE

Initial treatment:

Antibiotics: Yes / No / Unknown

If yes, please list antibiotics given: _____ Dates given: / / to / /

Acyclovir: Yes / No / Unknown Dates given: / / to / /

Interferon A: Yes / No / Unknown Dates given: / / to / /

Did patient require intensive care? Yes / No / Unknown

If yes, Date admitted to ICU: / / Date left ICU: / /

Was patient on mechanical ventilation? Yes / No / Unknown

Did patient have physical therapy and/or consult? Yes / No / Unknown

Has the patient received a blood transfusion/blood product/organ transplant within the last three weeks? Yes / No / Unknown

If yes, where was the transfusion/product received? _____ If yes, where was the organ transplanted? _____

If yes, when was the transfusion/product received? _____ If yes, when was the organ transplanted? _____

If yes, what volume of blood/product did the patient receive? _____ If yes, what organ was transplanted? _____

What was the patient's condition on discharge:

 Recovered Died Still in hospital Other: _____

Was the patient discharged to:

 Home Long-term care facility Still in hospital Other: _____

Ambulation on discharge:

 Fully Ambulatory with assistance Wheel chair Bedridden Unknown Other: _____

Activities of daily living:

 Unchanged from admission Impaired from admission Requires total assistance Unknown