

**WEST NILE VIRUS HUMAN SURVEILLANCE**  
**Patient Report to Hamilton Public Health Services** Version: May, 2006

Hospital Site \_\_\_\_\_ Patient Hospital Number \_\_\_\_\_ OHIP Number \_\_\_\_\_  
 Reported By \_\_\_\_\_ Responsible Physician \_\_\_\_\_ Telephone: ( ) \_\_\_\_--\_\_\_\_  
 Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
LAST FIRST (mm/dd/yyyy)  
 Patient address \_\_\_\_\_  
Number Street Name Apt Number City Province Postal Code  
 Patient Home Phone number ( ) \_\_\_\_--\_\_\_\_ Gender: Male  Female  Unknown

***To be completed by health care professional/infection control (Parts 1-5):***

***PART 1- Hospital Information and Diagnosis***

Admitting Diagnosis \_\_\_\_\_ Admit Date \_\_\_\_\_  
(mm/dd/yyyy)  
 Discharge Date \_\_\_\_\_ Date of Death (if applicable) \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

Suspect West Nile Neurological Syndrome Yes  No  Unknown   
 Suspect West Nile Non-Neurological Syndrome Yes  No  Unknown

***PART 2 – Clinical Presentation***

***Check all that apply and note onset date:***

Symptom Onset Date:  
(mm/dd/yyyy)

Fever (≥ 38°C or 100°F)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Headache	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Muscle Pain	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Muscle Weakness	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Rash	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Fatigue	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Lymphadenopathy	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Encephalitis	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Meningitis	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Acute Flaccid Paralysis	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Please Specify:		
Poliomyelitis-like Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Guillain-Barre-like Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	_____
Other (specify) _____		_____

***PART 3 – Travel History***

***In the previous three weeks was there travel:***

From: \_\_\_\_\_ To: \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

Within Ontario? Yes  No  To where \_\_\_\_\_ When: \_\_\_\_\_  
 To other provinces or countries? Yes  No  To where \_\_\_\_\_ When: \_\_\_\_\_

***PART 4 – Blood and Organ***

***In the previous 8 weeks, did the patient give or receive blood/plasma/tissue/organ? Yes  No***  \_\_\_\_\_  
(mm/dd/yyyy)

Details: \_\_\_\_\_

***PART 5 – Laboratory***

1 <sup>st</sup> serum taken?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	If yes, when _____
2 <sup>nd</sup> serum taken?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	If yes, when _____
Was CSF examined?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	If yes, when _____
If the patient died were pathology specimens tested?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	