NJDOH WEST NILE/OTHER DOMESTIC MOSQUITO-BORNE ARBOVIRAL DISEASE INVESTIGATION WORKSHEET

MR #: _____

CDRSS #: _____

DEMOGRAPHICS

Patient Last Name **First Name**	**DOB:** ____ / ____ / ____	**Phone number**
Address	**City**	**Municipality**

Race
☐ White ☐ Black ☐ American Indian or Alaskan Native
☐ Asian ☐ Pacific Islander ☐ Unknown

Ethnicity
◯ Hispanic ◯ Non-Hispanic ◯ Unknown

Sex
◯ Female
◯ Male
◯ Unknown/Not Stated

Industry (work setting)

Occupation (job title)

Works primarily:
◯ Indoors ◯ Outdoors ◯ Both ◯ Neither ◯ Unknown

Pregnancy status
◯ Pregnant ◯ Not pregnant
◯ N/A ◯ Unknown

CLINICAL INFORMATION

Date first seen by a medical professional.
____ / ____ / ____

Illness Onset Date
____ / ____ / ____

Diagnosis:
☐ WNV ☐ LAC
☐ EEE ☐ SLE
☐ JCV

Other, specify:

Complete all Signs/Symptoms with onset dates:

Yes	No	Unk	Sign/Symptom	Onset Date (MM/DD/YY)	Yes	No	Unk	Sign/Symptom	Onset Date (MM/DD/YY)
◯	◯	◯	Asymptomatic	____ / ____ / ____	◯	◯	◯	Meningitis	____ / ____ / ____
◯	◯	◯	Fever: _____°F	____ / ____ / ____	◯	◯	◯	Myalgia (muscle aches)	____ / ____ / ____
◯	◯	◯	Altered Mental Status	____ / ____ / ____	◯	◯	◯	Neurologic disorders (describe in "other")	____ / ____ / ____
◯	◯	◯	Arthralgia (Joint pain)	____ / ____ / ____	◯	◯	◯	Paralysis	____ / ____ / ____
◯	◯	◯	Chills	____ / ____ / ____	◯	◯	◯	Photophobia	____ / ____ / ____
◯	◯	◯	Diarrhea	____ / ____ / ____	◯	◯	◯	Rash	____ / ____ / ____
◯	◯	◯	Encephalitis	____ / ____ / ____	◯	◯	◯	Seizure	____ / ____ / ____
◯	◯	◯	Fatigue	____ / ____ / ____	◯	◯	◯	Stiff neck	____ / ____ / ____
◯	◯	◯	Headache	____ / ____ / ____	◯	◯	◯	Vertigo	____ / ____ / ____
◯	◯	◯	Impaired level of consciousness/ lethargy	____ / ____ / ____	◯	◯	◯	Vomiting	____ / ____ / ____
◯	◯	◯	Malaise	____ / ____ / ____	◯	◯	◯	Weakness	____ / ____ / ____

Other, specify:

Was an underlying immunosuppressive condition present?

◯ Yes, *specify*_____ ◯ No ◯ Unknown

Was patient hospitalized because of this illness?

◯ Yes, *specify location and date(s)*

Hospital name: _____

Admission: _____ / _____ / _____ Discharge: _____ / _____ / _____

Diagnosis:_____

◯ No

Did the patient die because of this illness?

◯ Yes, *specify date* _____ / _____ / _____

◯ No

◯ Unknown

In the 30 days before illness onset or diagnosis, did patient –

Travel outside of NJ (within the US)? ◯ Yes ◯ No ◯ Unk

Location/dates:_____

Travel outside of the US? ◯ Yes ◯ No ◯ Unk

Location/dates:_____

Receive a blood transfusion? ◯ Yes ◯ No ◯ Unk

Date: _____/_____/_____

Location: _____

Receive an organ transplant? ◯ Yes ◯ No ◯ Unk

Date: _____/_____/_____ Organ:_____

Location: _____

Does the patient work in a laboratory?

◯ Yes ◯ No ◯ Unk

Is the patient a healthcare worker?

◯ Yes ◯ No ◯ Unk

LABORATORY DATA

Was a lumbar puncture performed?

◯ Yes Date: _____ / _____ / _____

◯ No

Lumbar puncture findings:

WBC _____ % Lymphs _____ RBC _____

Glucose _____ Protein_____

Other notes:

Was a CBC performed?

◯ Yes Date: _____ / _____ / _____

◯ No

WBC _____ Platelets _____

Segs% _____ Lymphs%_____

Other notes:

Other laboratory tests performed and result:

West Nile virus	◯ Pos	◯ Neg	◯ Pending	**Dengue virus**	◯ Pos	◯ Neg	◯ Pending
La Crosse virus	◯ Pos	◯ Neg	◯ Pending	**Chikungunya virus**	◯ Pos	◯ Neg	◯ Pending
St. Louis encephalitis	◯ Pos	◯ Neg	◯ Pending	**Zika virus**	◯ Pos	◯ Neg	◯ Pending

Other relevant tests performed, specify:

Brain imaging scan performed: _____

Date: _____ / _____ / _____ Abnormal? ◯ Yes ◯ No Result: _____

Is CSF available for confirmatory testing?	**Is serum available for confirmatory testing?**
◯ Yes, *quantity available* _____ ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown

ADDITIONAL REQUIREMENTS	
Was this patient identified by blood donor screening?	◯ Yes ◯ No ◯ N/A
Not including around the home, did the patient spend significant time outdoors 2 weeks prior to onset?	◯ Yes ◯ No ◯ Unk If Yes, location address (other than primary address):
If hospitalized, what was the patient's discharge disposition?	◯ Home ◯ Rehabilitation ◯ Deceased ◯ N/A Other: _____
Does this case meet neuroinvasive disease conition?	◯ Yes ◯ No
In the 30 days before illness onset or diagnosis, did the patient donate an organ?	◯ Yes ◯ No ◯ Unk If Yes: Organ: _____ Date:____/_____/_____ Facility: _____
In the 30 days before illness onset or diagnosis, did the patient donate blood?	◯ Yes ◯ No ◯ Unk

TREATMENT INFORMATION
Was the patient treated with doxycycline? ◯ Yes ◯ No Doxycycline dates: ___/_____/_____ to ___/_____/_____
Did the patient's clinical status improve with doxycycline? ◯ Yes ◯ No

ADDITIONAL CASE NOTES