West Nile Virus Public Health Human Case Investigation Form[1]

Initial Investigation Date: ___/___/___(dd/mm/yy)

Investigation Form Submission Date: ___/___/___(dd/mm/yy)

Is this the first report submitted for this case?

□ Yes □ No □ Don't Know/Unsure

If No, please indicate the Update Number: □ Update Number_____

Investigation Completion Date: __/__/__ (dd/mm/yy)

SECTION A. PATIENT INFORMATION:

A1. Last name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

A2. First name |__|__|__|__|__|__|__|__|__|__| A3. Middle name |__|__|__|__|__|__|__|

A4. Initials: _____

A5. Date of Birth____/____/____(dd/mm/yy) (if Date of Birth not available;

A6. Age_____ years/ months/ weeks)

A7. Sex: □ Male □ Female □ Transgendered □ Unknown

A8. PHIN Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

A9. Occupation: _____

Place of Physical Residence:

A10. Street Address _____

A11. Apt _____

A12. City/Town/Village/Other

A13. Prov/Terr: _____

A14. Postal Code: _____

A15. Sec-Qtr-Twnshp-Rnge _____

[1] Highlighted sections are required to be reported to the CDC Unit within five working days.

A16. Municipality[2] _____

A17. RHA _____

Description: _____

Parish Lot: _____

Contact Information: (Mailing Address and Telephone)

A18. Street Address _____

A19. Apt _____

A20. City/Town/Village/Other _____

A21. P.O. Box _____ A22. Postal Code: _____

A23. Tel. H (____)____-_____ A24. W (____)____-_____

A25.	Notification of Physician	☐Yes	☐ No
	Notification of Patient	☐Yes	☐ No
	RM verified by Regional Public Health	☐Yes	☐ No
	Notification of RM	☐Yes	☐ No

A26. Country of Birth: _____

A27. Ethnicity

Aboriginal		☐Yes	☐ No	
	First Nations	☐Yes	☐ No	
	If yes to FN, is your primary residence on reserve?		☐Yes	☐ No
	Métis	☐Yes	☐ No	
	Inuit	☐Yes	☐ No	
	Other Aboriginal	☐Yes	☐ No	

[2] In some situations, the community where the patient resides is a formal municipality, however in other situations, the community is not the same as the municipality or rural municipality (e.g. Carman is its own municipality, not part of the RM of Dufferin, which surrounds it. Conversely, the community of Stony Mountain is not its own municipality but is part of the RM of Rockwood.) Please ensure the formal municipality or rural municipality is listed so that accurate analysis can be completed using this field.

Caucasian	□Yes	□ No
African/African-Canadian	□Yes	□ No
Asian	□Yes	□ No
Other	□Yes	□ No

SECTION B. CASE CLASSIFICATION*:

(Please consult the most recent version of the WNV Public Health Investigation Protocol for explanation of these categories)

B1.

		Suspect Case	Probable Case	Confirmed Case
198	West Nile virus Neurological Syndromes (WNNS)			
197	West Nile virus Non-Neurological Syndrome (WN Non-NS)			
196	West Nile virus Asymptomatic Infection (WNAI)	[redacted]		

B2. □ Update to Case Classification: (please tick when appropriate)

Date of update ____/__/__ (YYYYMMDD)

B3. Case is related to travel outside Province/Territory □ Yes □ No □ Don't Know/Unsure

B4. Have you received or donated blood/plasma/cells/tissues/organs within the previous 8 weeks of WNV symptom onset?

□Yes □ No □ Don't know □ Unsure

B5. If yes, was there a history of fever and/or headache within the week prior to donation?

□Yes □ No □ Don't know □ Unsure

B6. If the individual was a recipient or donor of blood, plasma, cells, tissue and/or organs, has Canadian Blood Services or Hema-Quebec, or relevant cell/tissue/organ donor organization been notified?

□Yes □ No □ Don't know □ Unsure

Date of notification to CBS ____/__/__ (YYYYMMDD)

* Requires review by Regional MOH

SECTION C. CLINICAL INFORMATION:

C1. Physician Name _____

C2. Date of onset of symptoms: ____/____/____ (dd/mm/yy)

C3. Was Lumbar Puncture performed? Yes ___ No ___

- CSF Laboratory results:

- Microbiology:
  - C&S: Gram stain: _____
  - Viral studies: _____

- Hematology:
  - Cell count: _____
  - WBC: _____ Diff: PMN: _____ Lymph: _____
  - RBC: _____

- Chemistry:
  - Glucose: _____
  - Protein: _____

- CSF Suggestive of Neurologic Disease? Yes ___ No ___

C4. Patient Status:

□ Hospital, Stable □Hospital, Other

□Home, Full Recovery □Home, Other

□ Died □Asymptomatic

□Don't know/Unsure

C5. Hospital name _____

C6. Date of Admission____/____/____ (dd/mm/yy) C6. Date of Discharge____/____/____ dd/mm/yy)

C7. Date of Death ____/____/____ (dd/mm/yy)

C8. If Died, how did West Nile virus relate to the cause of death;

□ Underlying cause of death

□West Nile virus contributed to the death, but was not the underlying cause

□West Nile virus did not contribute to the death, and was an incidental finding, or

□Unknown

C9. Patient Signs and Symptoms (To be completed with information from the case-patient)	**Yes**	**No**	**If yes, duration of symptoms ≥ 1 week: Please Check Yes or No below**	**Refused**	**Don't Know/ Unsure**
a) Fever (☐38° or 100°F)			☐ Yes ☐ No		
b) Headache			☐ Yes ☐ No		
c) Muscle pain			☐ Yes ☐ No		
d) Muscle weakness			☐ Yes ☐ No		
e) Joint pain			☐ Yes ☐ No		
f) Confusion or forgetfulness			☐ Yes ☐ No		
g) Blurred vision or deterioration in eyesight.			☐ Yes ☐ No		
h) Eyes sensitive to light			☐ Yes ☐ No		
i) Fatigue/Sleepiness			☐ Yes ☐ No		
j) Stupor and/or convulsions			☐ Yes ☐ No		
k) Stiff neck			☐ Yes ☐ No		
l) Respirator symptoms			☐ Yes ☐ No		
m) Fluctuation level of consciousness			☐ Yes ☐ No		
n) Maculopapular rash			☐ Yes ☐ No		
o) Paralysis			☐ Yes ☐ No		
p) Sensory deficits			☐ Yes ☐ No		
q) Involuntary movement			☐ Yes ☐ No		
r) Enlarged lymph nodes			☐ Yes ☐ No		
s) Other Neurological signs/symptoms: If yes, please specify:_____			☐ Yes ☐ No		
t) Other symptoms list: _____					

C10. West Nile Neurological Syndromes (To be completed with information from the health care provider)	**Yes**	**No**	**Don't Know /Unsure**
a) Meningitis			
b) Encephalitis			
c) Meningoencephalitis			
d) Acute Flaccid Paralysis If Yes, please specify:			
e) Poliomyelitis-like Syndrome			
f) Guillain Barré-like Syndrome (GBS)			
g) Other			
h) If Yes, please specify: _____ _____ _____ _____			
i) Movement disorders (e.g. tremors, myoclonus)			
j) Parkinsonism or Parkinsonian-like conditions(e.g. cogwheel rigidity, bradykinesia, postural instability)			
k) Rhabdomyolysis			
l) Respiratory failure			
m) Peripheral neuropathy			
n) Polyradiculopathy			
o) Optic neuritis			
p) Acute demyelinating encephalomyelitis (ADEM)			
q) Other neurological syndromes as described in the *Note* in the Health Human Case Investigation Protocol under Case Definitions: A Summary: _____ _____ _____			

C11. Other health conditions?	Yes	No	Refused	Don't Know /Unsure
a) Cancer				
b) Heart Disease				
c) Diabetes				
d) Alcoholism				
e) Cerebrovascular disease				
f) Liver disease				
g) Lung disease				
h) Renal disease				
i) Transplant recipient				
j) Immune suppressive medication i.e.: prednisone, chemotherapy, etc.				
k) Other chronic health condition(s) If Yes, please specify: _____ _____ _____				

C12. Are you currently pregnant?

□ Yes □ No □ Refused □ Don't Know/Unsure

C13. Are you currently breastfeeding?

□ Yes □ No □ Refused

If yes to C12 or C13, advise MOH

SECTION D. TRAVEL AND RESIDENCE HISTORY

D1. a) In the last 10 years, have you lived or traveled outside Canada? (This may be useful for interpretation of lab results)

□ Yes □ No □ Refused □ Don't Know/Unsure

b) If Yes, please provide the following information:

Year(s)	Country	Province/State

SECTION E. IMMUNIZATION HISTORY

E1. Have you been vaccinated against Japanese Encephalitis (JE)?

□ Yes □ No □ Refused □ Don't Know/Unsure

E2. Have you been vaccinated against Yellow Fever (YF)?

□ Yes □ No □ Refused □ Don't Know/Unsure

E3. Have you been vaccinated against any other arboviruses?

□ Yes □ No □ Refused □ Don't Know/Unsure

If yes, please specify: _____

SECTION F. MODE OF TRANSMISSION

Mode(s) of Transmission (Please tick all that apply)	**Possible**	**Not Possible**	**Uncertain**	**Refused to Answer**	**No Information Available**	**Most Likely Mode of Transmission †**
F1. Mosquito transmission						
F2. Non-Mosquito transmission, including:						
a) Receipt of blood component						
b) Receipt of Cells/Organ/Tissue transplant						
c) Patient is breastfed infant						
d) Patient is infant infected *in utero*						
e) Occupationally acquired infection If Yes, please specify: _____						
i. Laboratory or testing facility _____						
ii. Other If Yes, please specify: _____						
f) Handling sick/dead birds If yes, please describe: _____						
g) Other route of transmission If Yes, please specify: _____ _____						

† Please indicate the "Most Likely Mode of Transmission", choosing only one. This determination should be based on ALL relevant information collected on the case-patient.

SECTION G. EXPOSURES:

G1. Did you camp or go to the cottage within Manitoba during the 15 days prior to the onset of symptoms?

□Yes □ No □ Refused □ Don't Know/Unsure

G2. If Yes,

a) Where: _____

b) Date of travel: _____

G3. Do you use personal insect repellent(s) when outside/outdoors?

□ Never □ Sometimes

□ Most of the time □ Always

G4. Do you work outdoors?

□ Yes □ No □ Refused □ Don't Know/Unsure

If yes, check the appropriate box.

□ Farming

□ Other

G5. Did you participate in the following outdoor hobbies between dusk and dawn during the 15 days prior to the onset of symptoms?

□ Hunting □ Fishing □ Gardening

□ Golfing □ Walking/Jogging □ Other _____

G6: Have you been previously diagnosed with WNV?

□Yes □ No □ Refused □ Don't Know/Unsure

G7: If yes, what was the date of diagnosis?

Date: _____

G8. Other than your municipality* of residence do you think that there are more likely locations of exposure to mosquitoes within 15 days prior to the onset of symptoms, such as locations where you spent a lot of time outdoors especially between dusk and dawn? Please identify it here. (to be completed by MOH or public health designate) including travel outside of province.

Exposure Location #1:

Street Address _____ Apt _____

City/Town/Village/Other _____ Prov/Terr: _____ Country: _____

Postal Code: ____ _____ Sec-Qtr-Twnshp-Rnge _____

Municipality _____

RHA _____

Description: _____

Exposure Location #2:

Street Address _____ Apt _____

City/Town/Village/Other _____ Prov/Terr: _____ Country: _____

Postal Code: ____ _____ Sec-Qtr-Twnshp-Rnge _____

Municipality _____

RHA _____

Description: _____

Exposure Location #3:

Street Address _____ Apt _____

City/Town/Village/Other _____ Prov/Terr: _____ Country: _____

Postal Code: ____ _____ Sec-Qtr-Twnshp-Rnge _____

Municipality _____

RHA _____

Description: _____

* Municipality means city, town or RM where you reside.

G11. MOST LIKELY LOCATION OF EXPOSURE (Based on all exposure information, please indicate a final determination as to one most likely location of exposure. Check one.

Place of Residence: □ Exposure 1: □ Exposure 2: □ Exposure 3: □

SECTION H. REPORTED BY

Health Unit/Regional Health Authority or Other Health Organization:

a) Name _____

b) Position _____

c) Regional Health Authority _____

d) City/Town _____

f) Telephone: _____-_____-_____

Adapted from:

- ***Manitoba WNV 2003 Surveillance Database***
- ***National Core (7) and Minimum (9)Data Elements (2004)***
- ***OCMOH line listing 2003***
- ***Additional key elements requested for inclusion through consultations with MOHs and the OCMOH.***