ENHANCED SURVEILLANCE REPORT
WEST NILE VIRUS INFECTION (2006)

Case Count _____
(For AHW use only)

Please fax completed reports to (780) 644-7092
Attn: WNv Human Surveillance Coordinator
Phone (780) 644-0004

Instructions:
1. This form is to be filled out in addition to the Notifiable Disease Report (NDR) form.
2. Clinical information related to West Nile virus-related Syndrome (Page 3 of the form) is to be completed ***by a physician or MOH/designate in consultation with client's physician*** only if the patient/client is classified as having WN Neurological Syndrome (WNNS).

Report Date: _____/_____/_____ (yyyy/mm/dd)

NDR #_____

Is this the first Enhanced Surveillance Report submitted for this case? O Yes O No If No, please provide Update Number _____

SECTION A. REPORTER INFORMATION

Person reporting: Last name _____ First Name_____
RHA _____ Tel: _____-_____-_____
In the event that the patient/client was unavailable for consultation in completing this report, please check
O and provide brief explanation:
_____
Was a physician consulted for any of the patient/client information? O Yes O No
If yes, List physician contact information: Last name _____First name _____
City/Town_____ Prov _____
Tel: _____-_____-_____

SECTION B. PATIENT/CLIENT INFORMATION:

Last name _____ First name _____Middle name _____
Date of Birth ____/____/____(yyyy/mm/dd) (if Date of Birth not available; Age____ years/ months/ weeks)
Sex: O Male O Female O Unknown PHN _____
Regional Health Authority: _____
The First Nations and Inuit Health Branch, Health Canada, is very interested in collecting the following information for public health measures for First Nations and Inuit peoples:
Is client/patient Aboriginal? O Yes O No O Refused to answer
If Yes, please specify: O First Nations O Métis O Inuit O Non-status Indian
If Yes, is primary residence on reserve? O Yes O No

SECTION C. CASE CLASSIFICATION (*please check applicable classification*)

Consult the 2006 WNv Alberta Case Definitions for explanation of categories online:
http://www.health.gov.ab.ca/public/wnv_professionals.html

	Suspect	Probable	Confirmed
West Nile Neurological Syndrome (WNNS)			
West Nile Non-Neurological Syndrome (WN Non-NS)			
West Nile Asymptomatic Infection (WNAI)			

SECTION D. PREGNANCY INFORMATION

In the three (3) weeks prior to date of symptom(s) onset, was patient/client pregnant?

O Yes O No O Unknown O Not applicable

If Yes, please specify the expected confinement date (ECD): Date _____/_____/_____ (yyyy/mm/dd)

Has the prenatal medical care provider has been notified? O Yes O No O Unknown

SECTION E. TRAVEL AND RESIDENCE HISTORY

Did the patient/client travel more than 100 km distance (1 hour drive on highway roads) from his/her residence in the three (3) weeks *before onset of symptoms*? O Yes O No O Unknown

If Yes please provide the following information:

City/Town	Province/Territory/State	Country
For AHW use only: Is case related to travel to WNv endemic area? O Yes O No O Unknown If YES, specify travel location:		

SECTION F. CLINICAL INFORMATION:

Hospitalized: O Yes O No O Unknown Hospital name_____

Symptom onset date ____/____/____ (yyyy/mm/dd) **(Please try to complete).**

OR O Asymptomatic → *if asymptomatic, skip to Section G*

Signs and Symptoms ***(to be completed with information from patient/client)***	**Yes**	**No**	**Don't Know /Unsure**
Fever (≥ 38^{o} or ≥ 100^{o}F)	O	O	O
Headache	O	O	O
Muscle pain	O	O	O
Joint pain	O	O	O
Confusion or unusual forgetfulness	O	O	O
Blurred vision or deterioration in eyesight	O	O	O
Eye sensitivity to light	O	O	O
Unusual fatigue/sleepiness	O	O	O
Weakness	O	O	O
Stiff neck	O	O	O
Rash	O	O	O
Enlarged glands	O	O	O
Other signs/symptoms (Please specify)	O	O	O

West Nile virus-related Neurological Syndrome **This section to be completed *by a physician or MOH/designate in consultation with client's physician* only if the patient/ client is classified as having Neurological Syndrome**	**Yes**	**No**	**Don't Know/ Unsure**
Viral meningitis	O	O	O
Viral encephalitis	O	O	O
Acute Flaccid Paralysis, please specify:	O	O	O
Poliomyelitis-like Syndrome	O	O	O
Guillain-Barré-like Syndrome (GBS)	O	O	O
Other, please specify:	O	O	O
Movement disorders (e.g. tremors, myoclonus)	O	O	O
Parkinsonism (e.g. cogwheel rigidity, bradykinesia, postural instability)	O	O	O
Rhabdomyolysis	O	O	O
Peripheral neuropathy	O	O	O
Polyradiculopathy	O	O	O
Optic neuritis	O	O	O
Ocular Motor Disorder	O	O	O
Acute demyelinating encephalomyelitis (ADEM)	O	O	O
Facial muscle weakness	O	O	O
Other, please specify:	O	O	O

Underlying health conditions (chronic and/or immunocompromising) that may influence WNv symptoms) **This section to be completed for *all* WNv case classifications**	**Yes**	**No**	**Don't Know/ Unsure**
Cancer: specify	O	O	O
Heart Disease, specify	O	O	O
Diabetes, specify	O	O	O
Alcoholism	O	O	O
Cerebrovascular disease, specify	O	O	O
Liver disease, specify	O	O	O
Lung disease, specify	O	O	O
Renal disease, specify	O	O	O
Immunocompromising condition(s), specify	O	O	O
Neurological disorder, specify	O	O	O
Musculoskeletal disorder, specify	O	O	O
Other chronic health condition(s), please specify:	O	O	O

SECTION G. MODES OF TRANSMISSION

POSSIBLE Modes of Transmission	**Yes**	**No**	**Don't Know/ Unsure**
Mosquito transmission	O	O	O
Non-Mosquito transmission, including:			
Receipt of blood component	O	O	O
Receipt of Organ/Tissue transplant	O	O	O
Breastfed Infant	O	O	O
Infant infected *in utero*	O	O	O
Laboratory-acquired infection	O	O	O
Occupationally acquired infection → if Yes, please specify:	O	O	O
Direct contact with sick/dead birds 3 weeks prior to symptom onset → if Yes, please specify	O	O	O
Other route of transmission, please specify:	O	O	O

Please identify the MOST LIKELY Mode of Transmission	**Tick only one mode**
Mosquito transmission	O **Note: unless other mode identified, tick as default**
Receipt of blood component	O
Receipt of Organ/Tissue transplant	O
Breastfed Infant	O
Infant infected *in utero*	O
Laboratory-acquired infection	O
Occupationally acquired infection	O
Direct contact with dead or sick birds	O
Other route of transmission, please specify	O

SECTION H. BLOOD/PLASMA/ORGAN(S)/TISSUE DONORS and RECIPIENTS

Blood, plasma or blood components	*Donated* in past 8 weeks? O No O Yes O Unknown	*Received* in past 8 weeks? O No O Yes O Unknown
Organs or tissues	*Donated* in past 8 weeks? O No O Yes O Unknown	*Received* in past 8 weeks? O No O Yes O Unknown

For any 'Yes' response in Section H: has the form '*Public Health Notification to Canadian Blood Services*' has been completed and processed? O Yes O No O Unknown