GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Health Emergency Preparedness and Response Administration

August 1, 2011

Dear Healthcare Providers,

The primary objective of the DC Department of Health's Human West Nile Virus Surveillance Program is to rapidly detect human illness due to mosquito borne diseases, especially WNV.

In continued efforts towards this goal, your assistance is valued and critical. Please use the attached case report form to report all cases of West Nile Virus to the Washington DC Department of Health, Health Emergency Preparedness and Response Administration, Division of Epidemiology- Disease Surveillance and Investigation. Additionally, please find attached the specimen submission protocol.

Thank you in advance for your assistance. Should you have any questions please feel free to contact the Division of Epidemiology-Disease Surveillance and Investigation at 202-442-8141.

Sincerely,

Beverly A. Pritchett
Senior Deputy Director

64 New York Avenue, NE, Suite 5000, Washington, DC 20002 (202) 671- 4222 FAX (202) 671- 0707

PHYSICIAN ALERT: WEST NILE VIRUS
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

The Department of Health (DOH) continues to emphasize the importance of active surveillance for human cases of West Nile Virus (WNV).

Clinical Description: Arboviral infections may be asymptomatic or may result in illnesses of variable severity sometimes associated with the central nervous system (CNS). Clinical syndrome can range from febrile headache to aseptic meningitis to encephalitis. Arboviral meningitis is characterized by fever, headache, stiff neck and pleocytosis. Arboviral encephalitis is characterized by fever, headache and altered mental status ranging from confusion to coma with or without signs of brain dysfunction.

Clinical criteria:

I. Neuroinvasive disease

- Fever (≥100.4°F or 38°C) as reported by the patient or a health-care provider, **AND**
- Meningitis, encephalitis, acute flaccid paralysis, or other acute signs of central or peripheral neurologic dysfunction, as documented by a physician, **AND**
- Absence of a more likely clinical explanation.

II. Non-neuroinvasive disease

- Fever (≥100.4°F or 38°C) as reported by the patient or a health-care provider, **AND**
- Absence of neuroinvasive disease, **AND**
- Absence of a more likely clinical explanation.

Laboratory criteria:

I. Confirmed

- Isolation of virus from, or demonstration of specific viral antigen or nucleic acid in, tissue, blood, CSF, or other body fluid, **OR**
- Four-fold or greater change in virus-specific quantitative antibody titers in paired sera, **OR**
- Virus-specific IgM antibodies in serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen, **OR**
- Virus-specific IgM antibodies in CSF and a negative result for other IgM antibodies in CSF for arboviruses endemic to the region where exposure occurred.

II. Probable

- Virus-specific IgM antibodies in CSF or serum but with no other testing.

Case Definitions: A case must meet one or more of the above clinical criteria and one or more of the above laboratory criteria.

Send Case Report Forms via FAX to:	Laboratory Testing Info:	Questions:
(202) 442-8060	(202) 535-2323	(202) 442-8141

Testing for West Nile Virus (WNV): Please submit >5.0 ml of serum (or plasma for virus isolation) and >1.0ml of CSF. Please do not submit whole blood. Convalescent specimens (2 weeks after initial specimen) should be clearly labeled as such so appropriate testing can be done. A copy of the case report must accompany each specimen/set of specimens submitted for testing.

Investigation #: _____
MPI#: _____ MMWR (yr—wk): _____--_____
THIS BOX for DC DOH USE ONLY

FINAL Dx: _____
☐ Confirm ☐ Probable ☐ Suspect ☐ Transfer ☐ Not a Case
THIS BOX for DC DOH USE ONLY

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
COMMUNICABLE DISEASE CASE REPORT FORM

Submitted by: _____ Date: _____

*Hospital/Laboratory/Physician: _____ *Phone No.: _____

*Disease: _____ Outcome: ☐ Survived ☐ Died ☐ Unknown

PATIENT INFORMATION

*Last Name: _____ *First Name: _____

*Address: _____ *City: _____ *State: ____ *Zip: _____

*Home Phone: _____ Work Ph: _____ Other Ph: _____

*Birth Date: _____ *Sex: ☐ Male ☐ Female

*Race: ☐ Black ☐ White ☐ Native American/Alaskan ☐ Asian/Pacific ☐ Unknown

(*Ethnicity*): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

*If Patient is a minor, Name of Parents(s): _____

Occupation/School: _____ or ☐ Food Handler ☐ Child Caregiver ☐ Attends School/Daycare

Household contacts, names, ages: _____

CLINICAL INFORMATION ☐ Acute Illness or ☐ Chronic Illness Patient Notified of Lab Result: ☐ Yes ☐ No

*Onset Date: _____ *Admission Date/Seen: _____ Discharge Date: _____

Symptoms and Duration: _____

Past medical history: _____

If female, is the patient pregnant? ☐ Yes ☐ No If yes, expected date of delivery? _____

DIAGNOSTIC TEST

*Collection Date	*Specimen Type	*Test	*Result

*Drug Resistant: ☐ Yes† ☐ No ☐ Unknown/Not Tested

†If Yes, list resistant Drugs: _____

TREATMENT

Date Started	Drug	Dosage	Duration

Additional Comments: _____

_____

64 New York Avenue NE, Fifth Floor • Washington DC, 20002 • Tel: (202)442-9371 • Fax: (202) 442-8060

***Minimum required information** by the DCMR, Title 22, Sections 215-218, 47 DCR 3493 (519-99)*

Revised Aug 2009