

Case Identification Number: _____

A16. Municipality or First Nations reserve _____

A17. RHA _____

Description: _____

Parish Lot: _____

Contact Information: Mailing Address and Telephone.

A18. Tel. H (____) ____ - ____ A19. W (____) ____ - ____

Check if same as above

A20. Street Address _____

A21. Apt _____

A22. City/Town/Village/Other _____

A23. P.O. Box _____ A24. Postal Code: _____

A25. Prov/Terr. _____

A26. Notification of Physician Yes No

Notification of Patient Yes No

RM verified by Regional Public Health Yes No

A27. Country of Birth: _____

A28. First Nations

- First Nations Yes No

: If yes to FN, is your primary residence on reserve? Yes No

Case Identification Number: _____

SECTION B. CASE CLASSIFICATION*:

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

B1.

198	West Nile virus Neurological Syndromes (WNNS)	
197	West Nile virus Non-Neurological Syndrome (WN Non-NS)	
196	West Nile virus Asymptomatic Infection (WNAI)	

Reviewed by MOH YES NO

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

Date of update ____/____/____ (yyyy/mm/dd)

SECTION C. CLINICAL INFORMATION:

C1. Physician Name _____

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

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 ____

* Requires review by Regional MOH

Case Identification Number: _____

C4. Patient Status:

- Hospital, Stable Hospital, Other
 Home, Full Recovery Home, Other
 Deceased Asymptomatic
 Don't know/Unsure

C5. Hospital name _____

C6. Date of Admission ____/____/____ (yyyy/mm/dd)

C7. Date of Discharge ____/____/____ (yyyy/mm/dd)

C8. Date of Death ____/____/____ (yyyy/mm/dd)

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 (<input type="checkbox"/> 38° or 100°F)			<input type="checkbox"/> Yes <input type="checkbox"/> No		
b) Headache			<input type="checkbox"/> Yes <input type="checkbox"/> No		
c) Muscle pain			<input type="checkbox"/> Yes <input type="checkbox"/> No		
d) Muscle weakness			<input type="checkbox"/> Yes <input type="checkbox"/> No		
e) Joint pain			<input type="checkbox"/> Yes <input type="checkbox"/> No		
f) Confusion or forgetfulness			<input type="checkbox"/> Yes <input type="checkbox"/> No		
g) Blurred vision or deterioration in eyesight.			<input type="checkbox"/> Yes <input type="checkbox"/> No		
h) Eyes sensitive to light			<input type="checkbox"/> Yes <input type="checkbox"/> No		
i) Fatigue/Sleepiness			<input type="checkbox"/> Yes <input type="checkbox"/> No		
j) Stupor and/or convulsions			<input type="checkbox"/> Yes <input type="checkbox"/> No		
k) Stiff neck			<input type="checkbox"/> Yes <input type="checkbox"/> No		
l) Respiratory symptoms			<input type="checkbox"/> Yes <input type="checkbox"/> No		

Case Identification Number: _____

m) Fluctuation in level of consciousness			<input type="checkbox"/> Yes <input type="checkbox"/> No		
n) Maculopapular rash			<input type="checkbox"/> Yes <input type="checkbox"/> No		
o) Paralysis			<input type="checkbox"/> Yes <input type="checkbox"/> No		
p) Sensory deficits-			<input type="checkbox"/> Yes <input type="checkbox"/> No		
q) Involuntary movement			<input type="checkbox"/> Yes <input type="checkbox"/> No		
r) Enlarged lymph nodes			<input type="checkbox"/> Yes <input type="checkbox"/> No		
s) Gastrointestinal symptoms			<input type="checkbox"/> Yes <input type="checkbox"/> No		
t) Other Neurological signs/symptoms: If yes, please specify: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No		
u) 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) Movement disorders (e.g. tremors, myoclonus)			
h) Parkinsonism or Parkinsonian-like conditions(e.g. cogwheel rigidity, bradykinesia, postural instability)			

Case Identification Number: _____

C10. West Nile Neurological Syndromes (To be completed with information from the health care provider)	Yes	No	Don't Know /Unsure
i) Rhabdomyolysis			
j) Respiratory failure			
k) Peripheral neuropathy			
l) Polyradiculopathy			
m) Optic neuritis			
n) Acute demyelinating encephalomyelitis (ADEM)			
o) 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) Hypertension				
d) Diabetes				
e) Alcoholism				
f) Cerebrovascular disease				
g) Liver disease				
h) Lung disease				
i) Renal disease				
j) Transplant recipient				
k) Immune suppressive medication i.e.: prednisone, chemotherapy, etc.				
l) Other chronic health condition(s) If Yes, please specify: _____ _____ _____				

Case Identification Number: _____

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

C14. Have you received or donated blood/plasma/cells/tissues/organs within the previous 8 weeks of WNV symptom onset?

- No Donated Received Don't know/unsure

C15. If yes, was there a history of fever and/or headache within the week prior to donation?

- Yes No Don't know/unsure

C16. 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 ____/____/____ (yyyy/mm/dd)

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 and relates to potential previous exposure/infection of other flaviviruses as IgG can last at least 10 years in most individuals)

- Yes No Refused Don't Know/Unsure

b) If Yes, please provide the following information:

Year(s)	Country	Province/State

Case Identification Number: _____

SECTION E. IMMUNIZATION HISTORY (Useful for interpretation of lab results as vaccination with other flaviviruses can give rise to cross reactivity IgG antibody).

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(S) OF TRANSMISSION (The determination of the “most likely mode of transmission” should be based on ALL relevant information collected on the case-patient.)

F1. Please check any potential modes of transmission from the list below (all that apply):

- i) Receipt of blood component ii) Receipt of Cells/Organ/Tissue transplant
iii) Patient is a breastfed infant iv) Patient is an infant infected *in utero*
v) Handling sick/dead birds vi) Occupationally acquired: Laboratory or testing facility
vii) Occupationally acquired : other
viii) Mosquito bite ix) Other route of transmission

F2. What was the **most likely** mode of transmission from the list above (pick one). _____

F2a. For Sections v, vi, vii, ix , please specify either location or type of transmission, or activity involved in possible mode of transmission:

SECTION G. EXPOSURES:

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

- Yes No Don't Know/Unsure

G2. Have you spent time outdoors in the last 15 days prior to the onset of symptoms, between dusk and dawn?

- Yes No Don't Know/Unsure

If Yes, indicate which of the following activities you participated in:

- Hunting Fishing Gardening Paid work farming
 Golfing Walking/Jogging Other _____

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

- Never Sometimes
 Most of the time Always

G4: Have you been previously diagnosed with WNV?

- Yes No Don't Know/Unsure

G5: If yes, what was the date of diagnosis?

Date: _____ (yyyy/mm/dd)

Case Identification Number: _____

G6. 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? Take into account all outdoor activities, amount of time spent doing these activities between dusk and dawn, and location where you spent the majority of the 15 days prior to the onset of symptoms. Please identify it here, (to be completed by MOH or public health designate) including travel outside of province.

Exposure location #1	Exposure Location #2	Exposure location #3
Street Address _____ _____ _____ _____ Apt _____	Street Address _____ _____ _____ _____ Apt _____	Street Address _____ _____ _____ _____ Apt _____
City/Town/Village/Other _____ _____	City/Town/Village/Other _____ _____	City/Town/Village/Other _____ _____
Prov/Terr: _____ _____ Country: _____	Prov/Terr: _____ _____ Country: _____	Prov/Terr: _____ _____ Country: _____
Postal Code: _____ Sec-Qtr-Twnshp-Rnge _____ _____ _____	Postal Code: _____ Sec-Qtr-Twnshp-Rnge _____ _____ _____	Postal Code: _____ Sec-Qtr-Twnshp-Rnge _____ _____ _____
Municipality _____ _____ _____ _____ _____	Municipality _____ _____ _____ _____ _____	Municipality _____ _____ _____ _____ _____
RHA	RHA	RHA
Dates of travel/activity	Dates of travel/activity	Dates of travel/activity

G7. MOST LIKELY LOCATION OF EXPOSURE Based on all exposure information, please indicate a final determination as to one most likely location of exposure. **Most likely exposure would be where the individual spent the most days outdoors between dusk and dawn within the 15 day incubation period.** Check one.

Place of Residence: Exposure 1: Exposure 2: Exposure 3:
 G8 Case is related to travel outside Province/Territory Yes No Don't Know/Unsure

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

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: _____ - _____ - _____

For Office Use Only:(To be completed by West Nile Virus Program staff).

<p>C9 If Died, how did West Nile virus relate to the cause of death;</p> <ul style="list-style-type: none"> <input type="checkbox"/> Underlying cause of death <input type="checkbox"/> West Nile virus contributed to the death, but was not the underlying cause <input type="checkbox"/> West Nile virus did not contribute to the death, and was an incidental finding, or <input type="checkbox"/> Unknown at time of investigation
<p>File Incomplete and missing information:</p> <p>Unable to contact patient <input type="checkbox"/> Patient refused to answer <input type="checkbox"/></p> <p>Classification missing:</p> <p>No form completed <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Information unable to be obtained <input type="checkbox"/></p> <p>Symptom onset date: <u>Unknown</u> <input type="checkbox"/> Unable to determine <input type="checkbox"/></p> <p>Exposure location information: Unable to identify most likely location <input type="checkbox"/></p> <p style="padding-left: 100px;">More than one likely exposure location <input type="checkbox"/></p> <p>Avidity testing Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Previous year exposure Yes <input type="checkbox"/> No <input type="checkbox"/></p>

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.***