

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health**



**Division of Epidemiology-Disease Surveillance and Investigation
Office of the Director**

October 21, 2014

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 disease, 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, Office to the director, 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 question please feel free to contact the Division of Epidemiology-Disease Surveillance and Investigation at 202-442-8141.

Sincerely,

A handwritten signature in black ink, appearing to read "John O. Davies-Cole".

John O. Davies-Cole, PhD, MPH
State Epidemiologist

**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

- Fever ($\geq 100.4^{\circ}\text{F}$ 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

- Fever ($\geq 100.4^{\circ}\text{F}$ 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) 442-5836	(202) 442-5836

Testing for West Nile Virus (WNV): Please submit >5.0 ml of serum (or plasma for virus isolation) and >1.0 ml 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.





**Government of the District of Columbia
Department of Health
Communicable Disease Report Form**



Division of Epidemiology-Disease Surveillance & Investigation (DE-DSI)
Office of the Director

Investigation ID: _____
MMWR Wk: _____ Year _____
THIS BOX FOR DC DOH USE ONLY

Final Dx: _____
 Confirmed Probable Suspect Transfer Not a case
THIS BOX FOR DC DOH USE ONLY

NOTE: This form should be used for all reportable conditions EXCEPT the following: HIV, Tuberculosis, Hepatitis, and STDs

Clinical/Suspected Diagnosis: _____ Outcome: Survived Deceased Date of death
Submitted by: _____ Date: _____ Phone: _____
*Affiliation/Organization: _____ Hospital Laboratory Clinic Fax: _____

PATIENT INFORMATION

*Last Name: _____ *First Name: _____ MRN: _____
Address: _____ *City: _____ *State: _____ *Zip: _____
*Birth Date: _____ *Home Phone: _____ Work Phone: _____ Other Phone: _____
Occupation: _____ Food Handler Child Caregiver Health care worker
School/Daycare Attends _____ Sex: Male Female
*Race: Black White Asian/Pacific Islander Native American/Alaskan Unknown
Ethnicity: Hispanic Non-Hispanic Household contacts: names/ages: _____
If patient is a minor, name of Parent(s)/guardian(s): _____

CLINICAL INFORMATION

Acute illness Chronic Illness Patient notified of lab result? Yes No
Date of visit: _____ Admitted? Yes No Discharge Date: _____
Name of health care provider patient seen by: _____
Past Medical History _____ Symptom onset date: _____
Symptoms: _____ Symptom Duration: _____
Referred to/Follow-up: _____

DIAGNOSTIC TEST

*Collection date	*Specimen Type	Test	Result Date	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Drug resistant: Yes# No Unknown/Not tested
#If Yes, resistant drugs: _____ (Please include the laboratory results with this form)

TREATMENT

Date Started	Drug	Dose	Route	Frequency	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Additional Comments: _____

Please Fax This Form to DE-DSI: (202) 442-8060