Appendix I (e)
Human Case Investigation Report for West Nile Virus

Ministry of Health and Long-Term Care

Ministere de la Santé et des Soins de longue durée

Ontario

Human Case Investigation Report for West Nile Virus

Version: April 24, 2007

Instructions

The following questionnaire is for Public Health Unit use only. It is to be used as a guide for entering West Nile virus case data into the integrated Public Health Information System (iPHIS). No part of this questionnaire is to be sent to the Ministry of Health and Long-Term Care (MOHLTC).

Health Units are requested to report all cases who are potential blood, plasma, and/or tissue/organ donors or recipients to their closest Canadian Blood Service branch.

STATUS

Date Initial Action Taken: _____

Date Discharged from Follow-up: _____

Discharged By: _____

iPHIS Case ID _____

Client Initials _____

PART A. CLIENT INFORMATION

1. DEMOGRAPHICS:

Health Number |___|___|___|___|___|___|___|___|___|___|___|___|

Last name |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

First name |___|___|___|___|___|___|___|___|___|___|___| **Middle name** |___|___|___|___|___|___|___|

Gender: ☐ **Male** ☐ **Female** ☐ **Transgender** ☐ **Other** ☐ **Unknown**

Date of Birth ____/____/____ **(yyyy-mm-dd)** ☐ **Accurate Date**

Street No _____ **Street Name** _____ **Type** _____

Direction _____ **Unit No** _____**City/Town**_____

Prov _____ **Postal Code:** _____ _____

Telephone **H (_____)** _____ - _____ **W (_____)** _____ - _____

Origin: ☐ **Non-Aboriginal Born in Canada** ☐ **Born Outside Canada**

☐ **Registered/Status Indian** ☐ **Metis**

☐ **Inuit** ☐ **Unknown**

☐ **Other aboriginal (specify)** _____

2. FIRST NATIONS

On Reserve most of the time

☐ **Yes** ☐ **No** ☐ **Not Applicable** ☐ **Don't Know**

iPHIS Case ID _____

Client Initials _____

3. BLOOD OR ORGAN DONOR, OR RECIPIENT OF BLOOD COMPONENT OR ORGAN/TISSUE TRANSPLANT: (Information from the case-patient and/or health care provider) **Note that this screen must be accessed through the Outbreak Module, under the "client" heading.**

In the 8 weeks before onset of symptoms, and up to today, have you/has the patient:	**Yes**
Donated/received blood, plasma or blood components?	☐
if Yes, please specify: Date:_____/___/___(yyyy-mm-dd) **Hospital/Clinic/Physician_____** **City_____ Prov/Terr_____**	
Donated/received organs or tissues?	☐
if Yes, please specify: Date:_____/___/___(yyyy-mm-dd) **Hospital/Clinic/Physician_____** **City_____ Prov/Terr_____**	
*If the respondent replied **YES** to any of the above questions regarding blooddonation/ transfusion, has a representative of (1)Canadian Blood Services or (2)Hema-Quebec been notified?* *If the respondent replied **YES** to any of the above questions regarding organ transplant, has the hospital where the transplant occurred been notified?*	☐
if Yes, please specify contact information: Date _____/___/___ (yyyy-mm-dd) **Last Name: _____ First Name: _____** **Telephone: _____ - _____ - _____**	

PART B. CASE INFORMATION

1. CASE CLASSIFICATION:

Please see the "Ontario WNV Human Case Definition: Version July 4, 2005" for definitions of a Suspect, Probable and Confirmed case of WNV.

☐Person Under Investigation ☐Suspect ☐Probable ☐ Confirmed ☐ Does Not Meet

2. SYNDROME TYPE (WNNS, WN NON-NS OR WNAI):

Please select the appropriate syndrome type listed under the 'agent' field. The available choices are:

1. WN NON-NS (West Nile Virus Non-Neurological Syndrome)
2. WNNS - Neurologic complications (West Nile Virus Neurological Syndrome)
3. WNAI – Asymptomatic (West Nile Virus Asymptomatic Infection)

iPHIS Case ID _____

Client Initials _____

3. EXPOSURE INFORMATION

If multiple exposures are entered, please identify the most probable exposure in your list by checking it off. Also, if exact exposure dates are unknown, to calculate the earliest exposure date subtract 15 days from the onset of symptoms.

A. iPHIS Exposure Naming Convention:

{Exposure Location Name} – {Item} – {Earliest Exposure Date}

Example 1 - the exposure is a mosquito bite at home in 'A-town' when date of onset was August 16, 2005:

- **Home A-town – Mosquito – 2005/08/01**

Example 2 – the exposure is a mosquito bite while camping in 'B-park' when date of onset was August 30, 2005:

- **Park B-park – Mosquito – 2005/08/15**

Example 3 - the exposure is a mosquito bite while traveling in USA State X when date of onset was July 25, 2005:

- **Travel USA State X – Mosquito – 2005/07/10**

B. Exposure history in 3 weeks prior to symptom onset date:

Exposure 1: iPHIS Exposure Name_____

☐ **Most Likely Source**

Earliest Exposure Date _____/____/____ (yyyy-mm-dd)	Most Recent Exposure Date _____/____/____ (yyyy-mm-dd)

Exposure Address

Street Number	Street Name
Street Type	Street Direction
Unit	City
Postal Code	
Latitude*	Longitude*

Setting/Travel Location Description Details

Exposure Setting	Exposure Setting Type
Exposure Location Name	

Comments

iPHIS Case ID _____

Client Initials _____

Exposure 2: iPHIS Exposure Name_____

☐ **Most Likely Source**

Earliest Exposure Date _____/____/____ (yyyy-mm-dd)	Most Recent Exposure Date _____/____/____ (yyyy-mm-dd)

Exposure Address

Street Number	Street Name
Street Type	Street Direction
Unit	City
Postal Code	
Latitude*	Longitude*

Setting/Travel Location Description Details

Exposure Setting	Exposure Setting Type
Exposure Location Name	

Comments

*GIS coding can currently be placed in the UTM field or in the Address Comment field.

4. INTERVENTIONS/TREATMENTS: (Information from the case-patient)

Hospitalization:

1. Hospital name_____

Date of admission_____/____/____ (yyyy-mm-dd) Date of discharge_____/____/____ (yyyy-mm-dd)

2. Hospital name_____

Date of admission_____/____/____ (yyyy-mm-dd) Date of discharge_____/____/____ (yyyy-mm-dd)

5. OUTCOME

Outcome of the case is to be completed upon initial investigation.

☐ Recovered ☐ Pending ☐ Ill ☐ Residual Effects ☐ Fatal ☐ Unknown

Outcome Date: _____/____/____ (yyyy-mm-dd) ☐ Accurate

iPHIS Case ID _____

Client Initials _____

6. SIGNS AND SYMPTOMS

Note: This page may be utilized as a fax to gather symptom information from the appropriate health care provider. Please note that if Yes is checked off for a symptom, a start date must also be entered for that symptom. The Onset Date is to be checked off only for the one symptom that most likely represents the start of the illness.

CASE NAME (if page used as fax): _____

Patient Signs and Symptoms	Yes	No	Refused	Not Asked	Don't Know	Start Date	End Date	Onset Date*
Asymptomatic	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Confusion or unusual forgetfulness	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Diarrhea	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Facial muscle weakness	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Fatigue/sleepiness	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Fever (38ºC or 100ºF)	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Headache	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Joint pain	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Lymph nodes swelling/pain	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Malaise (general unwell feeling)	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Muscle pain (myalgia)	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Muscle weakness	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Nausea	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Neck, stiff	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Photophobia (eyes sensitive to light)	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Rash	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Vision, blurred/double	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Vision, deteriorating	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Vomiting	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐
Other	☐	☐	☐	☐	☐	___/___/___	___/___/___	☐

*****Please specify one symptom as the client's Onset Date.

NOTES: _____
_____

PLEASE RETURN FAX TO:

HEATH UNIT: _____ FAX: _____

iPHIS Case ID _____

Client Initials _____

7. COMPLICATIONS:

Note: This page may be utilized as a fax to gather complication information from the appropriate health care provider. (Complications are not listed in alphabetical order as in iPHIS, but are grouped to facilitate completion by health care provider.)

CASE NAME (if page used as fax): _____

West Nile virus-related Neurological Syndromes:	**Yes**	**Start Date**	**End Date**
None	☐	___/___/___	___/___/___
Acute demyelinating encephalomyelitis (ADEM)	☐	___/___/___	___/___/___
Acute Flaccid Paralysis: Poliomyelitis-like Syndrome	☐	___/___/___	___/___/___
Acute Flaccid Paralysis: Guillain Barré-like Syndrome (GBS)	☐	___/___/___	___/___/___
Acute Flaccid Paralysis, other	☐	___/___/___	___/___/___
Paralysis, other	☐	___/___/___	___/___/___
Blindness	☐	___/___/___	___/___/___
Optic neuritis	☐	___/___/___	___/___/___
Encephalitis	☐	___/___/___	___/___/___
Meningitis	☐	___/___/___	___/___/___
Seizures	☐	___/___/___	___/___/___
Movement disorders (e.g. tremors, myoclonus)	☐	___/___/___	___/___/___
Parkinsonism (e.g. cogwheel rigidity, bradykinesia, postural instability)	☐	___/___/___	___/___/___
Peripheral neuropathy	☐	___/___/___	___/___/___
Polyradiculopathy	☐	___/___/___	___/___/___
Rhabdomyolysis	☐	___/___/___	___/___/___
Unknown	☐	___/___/___	___/___/___
Other	☐	___/___/___	___/___/___

NOTES:_____
_____
_____

PLEASE RETURN FAX TO:

HEATH UNIT: _____ FAX: _____

iPHIS Case ID _____

Client Initials _____

8. RISKS – BEHAVIOURAL SOCIAL FACTORS:

Personal Protective Measures:

Case uses personal insect repellant(s) containing DEET when outside/outdoors?

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always ☐ Not Asked ☐ Unknown

Case uses other personal insect repellant(s) when outside/outdoors?

☐ Yes ☐ No ☐ Not Asked ☐ Unknown

Vaccination:

Case has been vaccinated for a flavivirus (i.e. Japanese Encephalitis virus, Yellow Fever virus)

☐ Yes ☐ No ☐ Not Asked ☐ Unknown

Exposure:

Case traveled more than 3 km from their residence in the three weeks prior to onset of symptoms?

☐ Yes ☐ No ☐ Not Asked ☐ Unknown

Case is a Travel Case – Outside of Health Unit, within Ontario

☐ Yes ☐ No ☐ Not Asked ☐ Unknown

Case is a Travel Case – Outside of Ontario

☐ Yes ☐ No ☐ Not Asked ☐ Unknown

9. LABORATORY TEST RESULTS: (Information provided by the Central Public Health Laboratory)

Requisition	**Sample Type (specify): Serum, CSF, or brain tissue**	**Collection Date (yy/mm/dd)**	**IgM ELISA Result**	**IgG ELISA Result**	**Nucleic Acid Test Results (e.g. PCR)**	**PRNT Titre**	**Other Test Result**	**Test Date (yy/mm/dd)**