



WEST NILE VIRUS - FAX REPORT

Today's Date _________

To: South Central District Health Fax: 736-3009

FROM: _____

Provider Contact person _____

Provider Contact telephone number _____

Patient's Name _____ Date of Birth _________

Home Address _____

Home Phone _____

Sex: M F Race/Ethnicity _____ Hospitalized? Yes No

Date of Symptom Onset _________ Date of Laboratory testing _________

Type of test: IgM ___ Other _____ Result _____

Please check all symptoms that apply under the selected category of disease exhibited by the patient.

___ **WEST NILE FEVER – NOT NEUROINVASIVE DISEASE** (check all that apply)

___Fever ___Headache ___Arthralgias ___Myalgias ___Fatigue ___Maculopapular Rash

___Lymphadenopathy ___Eye Pain ___Stiff Neck Other _____

___ **WEST NILE INFECTION – NEUROINVASIVE DISEASE** (check all that apply)

___Acutely altered mental status (e.g. disorientation, obtundation, stupor, confusion, or coma)

___ Other acute signs of central or peripheral neurological dysfunction (e.g. paresis or paralysis, nerve palsies, sensory deficits, abnormal reflexes, generalized convulsions, or abnormal movements)

___ Flaccid paralysis ___ Meningitis ___ Encephalitis

Other _____

**Thank you for submitting information in a timely manner to facilitate accurate information about current incidence of West Nile Virus infection in our local area.
(Full document available at <http://www.diseaseinfosouthidaho.org>)**