

**New Jersey Department of Health
REQUEST FOR HUMAN WEST NILE VIRUS TESTING
PATIENT INTAKE RECORD**

*Fields in **BOLD** are required information. Reports will not be processed if these fields are not completed.*

PLEASE CLEARLY PRINT ALL INFORMATION!

Date Form Being Submitted: ____ / ____ / ____

Date of First Symptoms (REQUIRED) ____ / ____ / ____

FOR NJDOH USE ONLY	
NJ ID:	_____
Date Report Rec'd:	____/____/____
Received By:	_____
Record Entry Date:	____/____/____
Approved for WNV Testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. IDENTIFYING PATIENT INFORMATION

Last Name				_____											
First Name												MI	_____		
Date of Birth				Age (years)				Sex							
____ / ____ / ____				Years				<input type="checkbox"/> Male <input type="checkbox"/> Female							
Street Address												Apt. No.			
City						State		Zip Code				County			
Home Telephone No.						Work Telephone No.									

2. REPORTED BY

Last Name				First Name									
Title (ICP, Resident, Attending, etc.)				Specialty (if applicable)									
Work Address				City				State				Zip Code	
Telephone No.				Pager No.				Fax No.					

3. PHYSICIAN TREATING PATIENT

Last Name				First Name									
Title (ICP, Resident, Attending, etc.)				Specialty (if applicable)									
Work Address				City				State				Zip Code	
Telephone No.				Pager No.				Fax No.					

Send Report to (check all that apply):

Physician Above Other Physician: _____

PATIENT INTAKE RECORD (Continued)

4. CLINICAL INFORMATION			
Admitting Diagnosis:			
<input type="checkbox"/> Encephalitis <input type="checkbox"/> Meningitis <input type="checkbox"/> Guillian-Barre Syndrome <input type="checkbox"/> Fever Syndrome <input type="checkbox"/> Other (specify): _____			
Was Patient Hospitalized?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Hospital Name		City	State
Medical Record Number	Admission Date	Discharge Date	
	___ / ___ / ___	___ / ___ / ___	
Fever:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Stiff Neck:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Headache:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Photophobia:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Altered Mental Status:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Seizure:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle Weakness:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rash:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other Neurologic Signs:	<input type="checkbox"/> Yes (specify): _____		<input type="checkbox"/> No <input type="checkbox"/> Unknown
Other Symptoms:	<input type="checkbox"/> Yes (specify): _____		<input type="checkbox"/> No <input type="checkbox"/> Unknown
Antiviral Treatment:	<input type="checkbox"/> Yes (specify): _____		<input type="checkbox"/> No <input type="checkbox"/> Unknown
Antibiotic Treatment:::	<input type="checkbox"/> Yes (specify): _____		<input type="checkbox"/> No <input type="checkbox"/> Unknown
PATIENT OUTCOME:			
<input type="checkbox"/> Recovered <input type="checkbox"/> Still in Hospital <input type="checkbox"/> Still Ill, Discharged Home <input type="checkbox"/> Unknown <input type="checkbox"/> Died - Date of Death: ___ / ___ / ___			
5. LABORATORY AND DIAGNOSTIC TESTING RESULTS			
Lumbar puncture performed? <input type="checkbox"/> Yes (Date Performed): ___ / ___ / ___ <input type="checkbox"/> No <input type="checkbox"/> Pending/Planned			
CSF Results: Glucose _____ Protein _____ RBC _____ WBC _____ % Lymph _____ % Segs _____			
Differential _____ %Polys _____ Gram Stain _____ Bacterial Culture _____			
Parasite or Fungal Culture _____ Viral culture _____			
If performed:			
CBC	Date: ___ / ___ / ___	WBC _____	%Lymph _____ %Segs _____
MRI	Date: ___ / ___ / ___	Result: _____	
EMG	Date: ___ / ___ / ___	Result: _____	
CT	Date: ___ / ___ / ___	Result: _____	
Vaccination History			
Yellow fever vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No List date(s) given: _____			
Other Pertinent Information (brief history, clinical findings or relevant lab data): _____ _____			

**Please fax completed form to (609) 588-2546,
Attention: WNV Human Surveillance, Communicable Disease Service, NJDOH.**

Once a report is received at the NJDOH, staff will contact you on whether this patient is approved for West Nile Virus testing. If approved for testing, we will provide additional information on shipping specimens. If you have any questions, please call (609) 588-3121.