# New Jersey Department of Health

**REQUEST FOR HUMAN WEST NILE VIRUS TESTING**

**PATIENT INTAKE RECORD**

**PLEASE CLEARLY PRINT ALL INFORMATION!**

<table>
<thead>
<tr>
<th>Date Form Being Submitted:</th>
<th>/   /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of First Symptoms (REQUIRED)</td>
<td>/   /</td>
</tr>
</tbody>
</table>

**1. IDENTIFYING PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Sex (Male/Female)</th>
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</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td>___ / ___ / ___</td>
<td>___ Years</td>
<td></td>
<td>Male/Female</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>Apt. No.</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Home Telephone No.</th>
<th>Work Telephone No.</th>
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**2. REPORTED BY**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Title (ICP, Resident, Attending, etc.)</th>
<th>Specialty (if applicable)</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Work Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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<table>
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<tr>
<th>Telephone No.</th>
<th>Pager No.</th>
<th>Fax No.</th>
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</table>

**3. PHYSICIAN TREATING PATIENT**

<table>
<thead>
<tr>
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<th>Zip Code</th>
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Send Report to (check all that apply):

- [ ] Physician Above
- [ ] Other Physician: ____________________________

**FOR NJDOH USE ONLY**

<table>
<thead>
<tr>
<th>NJ ID: _____________________</th>
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</table>

Date Report Rec’d: ___ / ___ / ___

Received By: ___________________

Record Entry Date: ___ / ___ / ___

Approved for WNV Testing?  [ ] Yes  [ ] No
### 4. CLINICAL INFORMATION

**Admitting Diagnosis:**
- Encephalitis
- Meningitis
- Guillain-Barre Syndrome
- Fever Syndrome
- Other (specify):

**Was Patient Hospitalized?**
- Yes
- No

**Hospital Name**

**City**

**State**

<table>
<thead>
<tr>
<th>Medical Record Number</th>
<th>Admission Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
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<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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</tbody>
</table>

**Fever:**
- Yes
- No
- Unknown

**Stiff Neck:**
- Yes
- No
- Unknown

**Headache:**
- Yes
- No
- Unknown

**Photophobia:**
- Yes
- No
- Unknown

**Altered Mental Status:**
- Yes
- No
- Unknown

**Seizure:**
- Yes
- No
- Unknown

**Muscle Weakness:**
- Yes
- No
- Unknown

**Rash:**
- Yes
- No
- Unknown

**Other Neurologic Signs:**
- Yes (specify):

**Other Symptoms:**
- Yes (specify):

**Antiviral Treatment:**
- Yes (specify):

**Antibiotic Treatment:**
- Yes (specify):

**PATIENT OUTCOME:**
- Recovered
- Still in Hospital
- Still Ill, Discharged Home
- Unknown

**Died - Date of Death:**

### 5. LABORATORY AND DIAGNOSTIC TESTING RESULTS

**Lumbar puncture performed?**
- Yes (Date Performed): ___ / ___ / ___
- No
- Pending/Planned

**CSF Results:**
- Glucose
- Protein
- RBC
- WBC
- % Lymph
- % Segs
- Differential
- % Polys
- Gram Stain
- 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?**
- Yes
- No
- List date(s) given:

**Other Pertinent Information (brief history, clinical findings or relevant lab data):**

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*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.