

WEST NILE VIRUS SPECIMEN SUBMITTAL FORM – PLEASE USE ONE FORM PER PATIENT

West Nile virus testing is recommended on individuals with the following:

- A. Encephalitis
- B. Aseptic meningitis (Note: Consider enterovirus for individuals ≤ 18 years of age)
- C. Acute flaccid paralysis; atypical Guillain-Barré Syndrome; transverse myelitis; or
- D. Febrile illness compatible with West Nile fever* and lasting ≥ 7 days (must be seen by health care provider):

* The West Nile fever syndrome can be variable and often includes headache and fever (T≥38C). Other symptoms include rash, swollen lymph nodes, eye pain, nausea or vomiting. After initial symptoms, the patient may experience several days of fatigue and lethargy.

INSTRUCTIONS FOR SENDING SPECIMENS

1. **Required specimens:**

- Acute Serum:** ≥ 2cc serum
- Cerebral Spinal Fluid (CSF):** 1-2cc CSF if lumbar puncture is performed

2. If West Nile virus is highly suspected and acute serum is negative or inconclusive:

- 2nd Serum:** ≥ 2 cc serum collected 3-5 days after acute serum

- Refrigerated specimens should be sent on **cold pack** using an overnight courier
- If CSF is frozen, send on dry ice (all specimens may be sent on dry ice)
- Each specimen should be labeled with **date of collection**, **specimen type**, and **patient name**
- Please do not send specimens on Fridays
- Send specimens to:

**West Nile Virus testing
Public Health Laboratory
1080 Emeline Avenue
Santa Cruz CA 95060**

**** IMPORTANT: THE INFORMATION BELOW MUST BE COMPLETED AND SUBMITTED WITH SPECIMENS ****

Patient's last name, first name:			Patient Information		
			Address _____		
			City _____ Zip _____ County _____		
Age or DOB:	Sex (circle): M F	Onset Date:	Phone Number (____) _____		
Clinical findings: <input type="checkbox"/> Encephalitis <input type="checkbox"/> Meningitis <input type="checkbox"/> Acute flaccid paralysis <input type="checkbox"/> Febrile illness <input type="checkbox"/> Other: _____			Other information (immunocompromised, travel hx, hx of flavivirus infection, etc.):		
Other tests requested:			This section for Laboratory use only. Date received and Accession Number		
1 st	Specimen type and/or specimen source	Date Collected	1 st		
2 nd	Specimen type and/or specimen source	Date Collected	2 nd		
3 rd	Specimen type and/or specimen source	Date Collected	3 rd		

Questions? Call 831/454-5445

Submitting Physician _____ Phone Number (____) _____

Submitting Facility _____ Phone Number (____) _____