California Department of Public Health – Viral and Rickettsial Disease Laboratory

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
   - ❑ **Cerebrospinal Fluid (CSF):** 1-2cc CSF may be submitted with acute serum for further testing at CDC if lumbar puncture is performed and residual CSF is available (Please note: these results may not be available for several weeks)
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

- ❑ Each specimen should be labeled with **date of collection**, **specimen type**, and **patient name**
- ❑ Refrigerated specimens should be sent on **cold pack** using an overnight courier
- ❑ Frozen specimens should be sent on **dry ice** using an overnight courier
- ❑ CSF that cannot be shipped within 24 hours of collection should be stored frozen at -70°C
- ❑ Serum that cannot be shipped within 24 hours of collection may be stored at 4°C or at -70°C
- ❑ Please do not send specimens on Fridays (Specimen Receiving Hours: M-F 8-5)
- ❑ Send specimens to: **Specimen Receiving – West Nile Virus**
  850 Marina Bay Parkway
  Richmond, CA 94804

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

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

Questions? Call Maria Salas at (510) 307-8606

Submitting Physician_____ Phone Number (_____) _____

Submitting Facility_____ Phone Number (_____) _____