Appendix A

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≥38°C). 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 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

- Each specimen should be labeled with **date of collection**, **specimen type**, and **patient name.**
- Serum that cannot be shipped within 48 hours of collection may be stored at 4°C or frozen at -20°C or colder.
- CSF that cannot be shipped within 72 hours of collection should be stored frozen at -70°C or colder.
- 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).
- Please do not send specimens on Fridays.
- Send specimens to: **Specimen Receiving**
  Public Health Laboratory
  3313 Chanate Road
  Santa Rosa, CA 95404

**** 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 Sonoma County Public Health Laboratory at (707) 565-4711.

Submitting Physician________________________ Phone Number (_____) ____________

Submitting Facility________________________ Phone Number (_____) ____________