

Diagnostic Testing Guidelines for West Nile Virus- Updated 2006

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

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 ($T \geq 38C$). 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.

1. **Required specimens:**

- Acute Serum:** ≥ 2 cc serum collected
- 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 (Specimen Receiving Hours: M-Th 8-5)
- Send specimens to Local Public Health Laboratory:

**2191 Johnson Ave.
San Luis Obispo, CA 93401**

- Local Public Health Laboratory West Nile **IFA/EIA IgM results** (or attach copy of results):

Specimen	Date Collected	IgM Assay Method	Results			
			Negative	Reactive	Indeterminate	Not Tested
		o IFA o EIA				
		o IFA o EIA				

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: O Encephalitis O Meningitis O Acute flaccid paralysis O Febrile illness O Other: _____			Other information (immunocompromised, travel hx, hx of flavivirus infection, etc.):			
Other tests requested:			This section for Laboratory use only.			
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			

For questions regarding specimens, please call 781-5507.

Submitting Facility _____ Phone Number (____) _____