State case number:_____ Lab number:_____

Washington State Department of Health

ARBOVIRAL ENCEPHALITIS/MENINGITIS CASE REPORT FORM

Case Identifying Information:

Last Name_____ First Name_____ Middle Initial ___

Date of Birth: _____/_____/_____ Gender: [ ]Male [ ]Female [ ]Unknown

Race: [ ]White [ ]Black [ ]Asian/PI [ ]Am Indian [ ]Other [ ]Unknown Ethnicity: [ ]Hispanic [ ]Nonhispanic [ ]Unknown

Street/RFD Address_____Apt. #_____

County_____ City/State/ZIP _____

Telephone: home (_____) _____ Occupation _____ work# (_____) _____

Clinical Information:

Date of onset: _____/_____/_____ Current diagnosis: [ ]Encephalitis [ ]Meningitis [ ]Febrile illness with acute onset

[ ] Other diagnosis (specify)_____

Hospitalized? [ ]Yes [ ]No [ ]Unknown If yes, name of hospital:_____

Date of admission: _____/_____/_____ Date of discharge: _____/_____/_____

Outcome: [ ]Alive [ ]Dead [ ]Unknown If patient died, date of death: _____/_____/_____

Primary clinician caring for patient/telephone #_____

Symptoms

Fever ≥100F or 38C	[ ]Yes	[ ]No	[ ]Unknown	Change in mental status	[ ]Yes	[ ]No	[ ]Unknown
Headache	[ ]Yes	[ ]No	[ ]Unknown	Stiff neck/meningeal signs	[ ]Yes	[ ]No	[ ]Unknown
Weakness	[ ]Yes	[ ]No	[ ]Unknown	Rash	[ ]Yes	[ ]No	[ ]Unknown
Gastrointestinal symptoms	[ ]Yes	[ ]No	[ ]Unknown	Seizures	[ ]Yes	[ ]No	[ ]Unknown
Myalgias	[ ]Yes	[ ]No	[ ]Unknown	Cranial nerve abnormalities	[ ]Yes	[ ]No	[ ]Unknown
Tremors	[ ]Yes	[ ]No	[ ]Unknown	Ataxia, extrapyramidal signs	[ ]Yes	[ ]No	[ ]Unknown

Acute flaccid paralysis [ ]Yes [ ]No [ ]Unknown If yes, complete acute flaccid paralysis form [ ]

Other signs/symptoms (specify)_____

Arthropod exposure (3-14 days before onset) [ ]Yes [ ]No [ ]Unknown Specify_____

Travel history (3-14 days before onset) [ ]Yes [ ]No [ ]Unknown If Yes, where?_____

Recent immunization (esp. yellow fever, JE) [ ]Yes [ ]No [ ]Unknown If Yes, when?_____/_____/_____ Type:_____

Received organ transplant or blood product within 30 days of onset [ ]Yes [ ]No [ ]Unknown If Yes, specify_____

Donated tissue/organ/blood product within 7 days of onset [ ]Yes [ ]No [ ]Unknown If Yes, specify_____

Pregnant [ ]Yes [ ]No [ ]Unknown If yes, due date _____/_____/_____

Breastfeeding [ ]Yes [ ]No [ ]Unknown If yes, birthdate of infant _____/_____/_____

Laboratory & Radiology Results

CSF obtained? [ ]Yes Date: ___/_____/___ [ ]No [ ]Unknown MRI/CT scan of head__[ ]Yes Date: ___/_____/___ [ ]No [ ]Unknown _____

CSF profile: WBCs_____(% lymphs_____% neutrophils_____) RBCs_____ Glucose_____ Protein_____

Peripheral WBC _____(% l ymphs_____% neutrophils_____% bands_____)

WNV Test results: Serology IgM_____Date: ____/_____/_____ IgG_____ Date: ____/_____/_____ Name of lab:_____

CSF IgM_____Date: ____/_____/_____ IgG_____ Date: ____/_____/_____ Name of lab:_____

Other arboviral test results (Virus isolation ; PCR) :_____

Person or agency reporting: _____

Address: _____ Telephone/pager# : _____

Date reported to local health jurisdiction: _____/_____/_

Return to: WDOH Communicable Disease Epidemiology FAX: 206.361.2930 Or mail: 1610 NE 150th St., Shoreline, WA 98155

Rev 3/7/2003