Arboviral Encephalitis

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Disease Under Investigation

* indicates required fields

- ○ *West Nile (WNV)*
- ○ *West Nile Fever*
- ○ *LaCrosse Encephalitis (LAC)*
- ○ *Eastern Equine Encephalitis (EEE)*
- ○ *St. Louis Encephalitis (SLE)*
- ○ *Western Equine Encephalitis (WEE)*
- ○ *Encephalitis (VEE)*
- ○ *Encephalitis (Powassan)*
- ○ *Encephalitis (Cache Valley)*

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial

Street Address

City	County	State	Zip
		West Virginia	

Is the patient's residence a:

- ○ *Correctional Facility (Specify)*_____
- ○ *Long Term Care Facility (Specify)*_____
- ○ *Shelter or Group Home (Specify)*_____
- ○ *None of the above*

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy

Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	County	State	Zip
		West Virginia	

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	**Age**	**Age Units** ○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native* ☐ *Asian*
☐ *Black or African American* ☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White* ☐ *Unknown*
☐ *Failure to report race/missing race* ☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy	**Date of diagnosis** mm/dd/yyyy

Was the patient hospitalized for the disease? ○ *Yes* ○ *No* ○ *Unknown*	**Name of Hospital**	**Date of Admission** mm/dd/yyyy

Patient outcome from this disease: ○ *Died* ○ *Survived* ○ *Unknown*	**Date of Death** mm/dd/yyyy

Clinical symptoms - Meningitis*:

Please check ALL symptoms that apply

☐ *Meningitis** ☐ *Fever; degrees:* ☐ *Headache* ☐ *Stiff Neck*
☐ *Photophobia* ☐ *Elevated WBC in CSF; WBC:* ☐ *Other; specify:*_____

Clinical symptoms - Encephalitis:**

Please check ALL symptoms that apply

☐ *Encephalitis*** ☐ *Seizures* ☐ *Confusion* ☐ *Coma*
☐ *Weakness* ☐ *Elevated CSF protein; result:* ☐ *Other; specify:*_____

Clinical symptoms - Other signs:

Please check ALL symptoms that apply

☐ *Nausea* ☐ *Vomiting* ☐ *Rash; describe:* ☐ *Lymphadenopathy* ☐ *Myalgia* ☐ *Arthralgia* ☐ *Other; specify:*_____

Did the patient receive anti-viral treatment? ○ *Yes* ○ *No*	**If Yes, what type of treatment?**

***Meningitis means acute onset of fever and meningeal signs (headache, fever, stiff neck, photophobia, nausea and vomiting) AND CSF white blood cell count (WBC) is elevated (> 5 white blood cells).**

****Encephalitis means acute onset of fever and signs of brain involvement (includes seizures, weakness, confusion, cognitive impairment, coma, sensory disturbances, etc.) CSF white cell count and/or CSF protein are elevated.**

Laboratory Data

Specimens

No.	Specimen Source	Date Collected	Antigen	Test Name	Result	Normal Range
	S=Serum C=CSF W=Whole Blood O=Other (specify below)	mm/dd/yyyy	W=WNV S=SLE L=LAC E=EEE O=Other (specify below)	1=IgM Capture EIA 2=IgG Capture EIA 3=IgM IFA 4=IgG IFA 5=NASBA 6=PCR/DNA Analysis 7=Other (specify below)		
1						
2						
3						
4						
5						

If Lab Data Was Unlisted, Specify Here

Specimen Source	Date Collected mm/dd/yyyy	Antigen	Test Name	Result	Normal Range

Laboratory Name	Phone ###-###-####	Ext.	Fax Number ###-###-####

Address	State:	Zip:
	West Virginia	

Reporting Source

Last Name	First Name	Phone ###-###-####	Ext.	Fax ###-###-####

Facility	Address

City	State	Zip	E-mail
	West Virginia		

Provider with Further Patient Information

Last Name	First Name	Phone ###-###-####	Ext.	Fax ###-###-####

Address	City	State	Zip
		West Virginia	

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy

Investigator	Date public health investigation began mm/dd/yyyy	Health Department	Phone ###-###-####

Ext.	

Investigation ID	Part of an Outbreak?	Outbreak Name	Lost to follow-up?
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

○ *Check if epi-linked to another case and complete information below*

Last Name of Epi-linked Case	First Name	DOB mm/dd/yyyy

County	Onset Date mm/dd/yyyy

Has the patient ever been immunized against yellow fever?	If YES, date mm/dd/yyyy
○ *Yes* ○ *No*	

Did the patient receive transfusion / organ transplantation in the 18 days prior to the onset of illness?	If YES, describe
○ *Yes* ○ *No*	

Has the patient given blood in the last 3 months?	If YES, Date mm/dd/yyyy	If YES, Location

Is patient pregnant	If YES, weeks gestation:	Is the patient breastfeeding?
○ *Yes* ○ *No*		○ *Yes* ○ *No*

During the 3 to 15 day period prior to the onset of symptoms, was the patient involved in outdoor activities?	If YES, give date mm/dd/yyyy	If YES, give locations
○ *Yes* ○ *No*		

Please complete the following travel history table. Include lifetime travel history to Dengue endemic regions AND all travel during the 3-15 day period prior to onset of symptoms.

Place	Date Arrived	Date Left
	mm/dd/yyyy	mm/dd/yyyy

Environmental Investigation

Observations Regarding Environment around the home

Item of interest	Present?	Number present	Distance	Description:
	Y=Yes N=No		from home (ft.)	
Containers ***				
Tires				
Standing Water ****				
Poorly draining gutters				
Plastic covers / tarps				
Other				

***** Defined as any artificial container that collects standing water.**

****** Such as pools, puddles, ponds, etc.**

Is the home in or near a wooded area?
○ *Yes* ○ *No*

If Yes, type of trees:
○ *Hardwoods* ○ *Evergreens* ○ *Other (Specify)*_____

If Yes, distance of wooded area from the home:

Location of Home in Latitude and Longitude (degrees, minutes, and seconds):

Latitude Degrees (N)	**Minutes**	**Seconds**
Longitude Degrees (W)	**Minutes**	**Seconds**

OR

Latitude (N) decimal degrees	**Longitude** (W) decimal degrees

Environmental investigator:

Date completed: mm/dd/yyyy

Recommendations Made to Patient / Family

(Check all that apply)

- ☐ *Wear Long sleeves and long pants; also wear hat and headnet if going into heavily infested areas*
- ☐ *Use mosquito repellant containing DEET according to label*
- ☐ *Get rid of tires, or any container outdoors that can hold standing water.*
- ☐ *Drain birdbaths, pots at least once a week*
- ☐ *Maintain or drain swimming pools*
- ☐ *Use 'dunks' (Bacillus thuringensis israeliensis) in standing water that cannot be drained.*
- ☐ *Clean gutters regularly*
- ☐ *Drill holes in bottom of trash cans / tires*
- ☐ *Fill ditches / make sure water flows freely*
- ☐ *Other*_____