CEP #: ________ Date form completed: _____/_____/_____

Encephalitis Case History Form

(Do not fill out West Nile case history form if this form is completed)

Case patients must be **hospitalized** with encephalopathy (depressed or altered level of consciousness ≥ 24 hours, lethargy, or change in personality) or ataxia, **AND** have 1 or more of the following: fever (T≥38C), seizure(s), focal neurologic findings, CSF pleocytosis, abnormal EEG or neuroimaging study. **Case patients must be ≥ 6 months of age and immunocompetent**.

Patient information:

Last Name ___________________________ **First Name** _____________________ **DOB** ____/____/____ **MR #** ______________

Street Address _____________________________ **City** ______________ **Zip code** _________ **Occupation** __________________

Tel (____)______________ **Name of surrogate decision-maker and/or guardian** ____

Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Other ☐ Unknown **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Gender: ☐ Female ☐ Male

Exposures (1 month before onset)

Animal or Arthopod contact: ☐ No ☐ Yes Details: ____

Immunization in last month: ☐ No ☐ Yes Details: ____

Medications (including OTC and herbal): ☐ No ☐ Yes Details: ____

Outdoor activating (camping, hiking, gardening, etc): ☐ No ☐ Yes Details: ____

Other pertinent exposures (including day care, head trauma, sick contacts, TB exposure etc)__________________________________

Travel (1 month before onset) – specify location and dates

☐ outside U.S. ___________________________ ☐ in U.S. _________________________ ☐ in CA ___________________________

☐ ever traveled outside the U.S. ____

Significant past history (medical, social, family, including rheumatologic disorders, early organ failure) _______________________

Glasgow Coma Scale: Please circle number corresponding to **level of neurological function on the day of maximal impairment**

Hospital day number ______

For patients age 6 months – 1 year

Eyes	
Opens spontaneously	4
Opens to command or shout	3
Opens to pain	2
Remains closed/no response	1
Verbal	
Normal smiles/coos/words	5
Appropriate cries or words	4
Inappropriate cries	3
Grunts	2
No response or intubated	1
Motor	
Localizes pain	5
Flexion-withdrawal	4
Abnormal flexion/decorticate	3
Abnormal extension/decerebrate	2
No response/flaccid or paralyzed	1

For patients age 2 years – 5 years

Eyes	
Opens spontaneously	4
Opens to verbal command	3
Opens to pain	2
Remains closed/no response	1
Verbal	
Normal words and phrases	5
Inappropriate words	4
Cries and/or screams	3
Grunts	2
No response or intubated	1
Motor	
Obeys commands	6
Localizes pain	5
Nonlocalizing movements	4
Abnormal flexion/decorticate	3
Abnormal extension/decerebrate	2
No response/flaccid or paralyzed	1

For patients age 6 years – adult

Eyes	
Opens spontaneously	4
Opens to speech	3
Opens to pain	2
Remains closed or paralyzed	1
Verbal	
Oriented	5
Confused/disoriented	4
Words (no sentences)	3
Sounds only (no words)	2
No response or intubated	1
Motor	
Obeys commands	6
Localizes pain	5
Nonlocalizing movements	4
Abnormal flexion/decorticate	3
Abnormal extension/decerebrate	2
No response/flaccid or paralyzed	1

Date of first CNS symptom(s) ____/____/____ **Date of hospital admission** ____/____/____

Previous hospitalization/ER visit (for current illness) ☐ No ☐ Yes specify facility/dates ____________________

Do the following apply during the current illness? (if yes, please provide clinical details):

In ICU	☐ No ☐ Yes Date: ____/____/______	
Intubated	☐ No ☐ Yes Date: ____/____/______	
Fever ≥ 38^0	☐ No ☐ Yes	____________
URI	☐ No ☐ Yes	____________
GI	☐ No ☐ Yes	____________
Rash	☐ No ☐ Yes	____________
Severe headache	☐ No ☐ Yes	____________
Lethargy	☐ No ☐ Yes	____________
Confusion	☐ No ☐ Yes	____________
Aphasia or mutism	☐ No ☐ Yes	____________
Extreme irritability	☐ No ☐ Yes	____________

Hallucinations	☐ No ☐ Yes	____________
Psychosis	☐ No ☐ Yes	____________
Dementia	☐ No ☐ Yes	____________
Stiff neck	☐ No ☐ Yes	____________
Ataxia	☐ No ☐ Yes	____________
Focal neurologic	☐ No ☐ Yes	____________
Muscle weakness	☐ No ☐ Yes	____________
Cranial nerve abn	☐ No ☐ Yes	____________
Seizures	☐ No ☐ Yes	____________
Intractable?	☐ No ☐ Yes	
Induced coma?	☐ No ☐ Yes Date: ____/____/______	
Coma	☐ No ☐ Yes Date: ____/____/______	

Brain CT date: ____/____/____
☐ normal ☐ abnormal ☐ not done
if abn: ☐ temporal lobe
☐ white matter demyelination
☐ hydrocephalus
☐ severe cerebral edema
☐ other ____________
____
____

Brain MRI date: ____/____/____
☐ normal ☐ abnormal ☐ not done
if abn: ☐ temporal lobe
☐ white matter demyelination
☐ hydrocephalus
☐ severe cerebral edema
☐ other ____________
____
____

EEG date: ____/____/____
☐ normal ☐ abnormal ☐ not done
if abn: ☐ diffuse slowing
☐ temporal epileptiform activity
☐ PLEDS
☐ other____________
____
____

CBC results (first available and subsequent)

Date	____/____/____	____/____/____
WBC	________	________
Diff	___/___/___/___ (seg/lymph/mono/eos)	___/___/___/___ (seg/lymph/mono/eos)
HCT	________	________
Plt	________	________

HSV PCR on CSF performed at hospital/commercial lab?

☐ No ☐ Yes Result: ☐ NEG ☐ POS
Date of LP ____/____/____

CSF results (first available and subsequent)

Date	____/____/____	____/____/____
OP	________	________
RBC	________	________
WBC	________	________
Diff	___/___/___/___ (seg/lymph/mono/eos)	___/___/___/___ (seg/lymph/mono/eos)
Protein	________	________
Glucose	________	________
CrAg	________	________
VDRL	________	________

Other labs/Xrays (list results if abnormal)

LFTs	☐ Normal	☐ Abnormal	☐ Not done	________
BUN/Cr	☐ Normal	☐ Abnormal	☐ Not done	________
ESR	☐ Normal	☐ Abnormal	☐ Not done	________
ANA	☐ Normal	☐ Abnormal	☐ Not done	________
Oligo bands	☐ Normal	☐ Abnormal	☐ Not done	________
Tox scren	☐ Normal	☐ Abnormal	☐ Not done	________
Heavy metals	☐ Normal	☐ Abnormal	☐ Not done	________
CXR	☐ Normal	☐ Abnormal	☐ Not done	________

Other____________________

Microbiological studies/results____________________
____
____
____

Treatment (specify type & date started)

Antiviral agents ____________________/___/___ Antibacterial agents ____________________/___/___

Steroids/IVIG ____________________/___/___

Contact physician information (*MANDATORY – FOR RELAYING RESULTS*)

Name ____________ Pager (___)____________ Fax (___)____________ E-mail ____________

Facility ____________________ City ____________

For questions regarding Project or specimen requirements, contact Somayeh Honarmand 510-307-8608 or pager 510-641-5286

Fax this form to 510-307-8599 or send with specimens to

Attn: Specimen Receiving/Encephalitis Project -- 850 Marina Bay Parkway, Richmond, CA 94804