New Hampshire Case Report **Arboviral Infection** **Encephalitis/Meningitis**	**This form must be faxed to the New Hampshire Bureau of Infectious Disease Control (603-696-3017) *and* a copy submitted with the laboratory specimen(s) to the NH Public Health Laboratories.**

PATIENT INFORMATION

Name: ____ Date of Birth: ____/____/____ ☐Male ☐Female
Last First MI mm dd yy

Home Address: ____ Homeless ☐Yes ☐No
Street City State Zip

Phone (H)______________________ (W)______________________ (Cell)______________________

RACE ☐White Black/African American ☐Asian ☐Native Hawaiian/Pacific Islander ☐American Indian/Alaska Native ☐Unknown

ETHNICITY ☐Unknown ☐Hispanic ☐Non-Hispanic

CLINICAL INFORMATION

Current Diagnosis: ☐Encephalitis ☐Meningitis ☐Other______________________

Hospitalized? ☐ Yes ☐ No If yes, Hospital: ______________________

Date of Admission: ____/____/____ Date of Discharge/Transfer: ____/____/____

Physician/Provider: ______________________ Phone: ______________________

SYMPTOMS: Date of first symptoms ____/____/____ Date of first *neurologic* symptoms ____/____/____

	YES	NO	UNK		YES	NO	UNK		YES	NO	UNK
Fever ≥100 ºF	☐	☐	☐	Disorientation	☐	☐	☐	Convulsions	☐	☐	☐
Highest Temp (if known)	____________ºF			Delirium	☐	☐	☐	Paralysis/ Paresis	☐	☐	☐
Headache		☐	☐	Lethargy	☐	☐	☐	Acute Flaccid Paralysis	☐	☐	☐
Stiff Neck	☐	☐	☐	Stupor	☐	☐		Cranial Nerve Palsy	☐	☐	☐
Tremor	☐	☐	☐	Coma	☐	☐		Rash	☐	☐	☐
Vomiting/ Nausea	☐	☐	☐	Muscle Weakness	☐	☐	☐	Location of Rash	____________		
Diarrhea	☐	☐	☐	Hyperreflexia	☐	☐	☐	Hemorrhage	☐	☐	☐
Confusion	☐	☐	☐	Muscle Pain	☐	☐	☐	Joint Pain	☐	☐	☐
Seizures	☐	☐	☐	Rigidity	☐	☐	☐				

Other______________________

OUTCOME ☐Recovered ☐Residual Symptoms ☐Died ☐Unknown If patient died, date of death ____/____/____

LABORATORY INFORMATION/TEST RESULTS (attach laboratory sheets)

Acute specimens (serum or CSF) must be collected within 3 to 10 days after onset of symptoms. Convalescent specimens should be collected 2-3 weeks after acute sample. If CSF is collected and submitted, please include serum sample.

CSF (specify units) Date ____/____/____ Abnormal? ☐Yes ☐No ☐Unknown Glu_______ Prot_______ RBC_______

WBC_______ Diff. Segs%_______ Lymphs%_______ Gram stain_______________ Bacterial Culture__________________

Fungal/Parasitic tests________________ Viral test results (Culture/Serology/PCR)______________________

CBC (specify units) Date ____/____/____ WBC_______ Diff.Segs%________ Lymphs%_______

MRI Date ____/____/____ Result______________________

CT Date ____/____/____ Result

EMG Date ____/____/____ Result

Antiviral Treatment Yes No Unk Date Started:_____/_____/_____

RISK FACTOR INFORMATION FOR PRELIMINARY OR CONFIRMED POSITIVE CASES OF ARBOVIRAL ILLNESS

1. Does the patient's residence have screened windows? ☐ Yes ☐ No ☐ Unknown

2. During the two weeks before onset of illness does the patient recall being bitten by mosquitoes?

   ☐Yes ☐No If yes, dates and places ____

3. Is the patient a smoker? ☐Yes ☐No ☐Unknown

   If yes, do they smoke outdoors? ☐Yes ☐No ☐Unknown

4. On average, how much time has the patient spent outdoors each day in the two weeks prior to onset? ______________________

   List any unusually long periods spent outside during the two weeks prior to onset:____

5. Does the patient use any prevention measures to avoid mosquito bites? ☐Yes ☐No ☐Unknown

   If yes, list ____

   Does the patient use mosquito repellent when outdoors: ☐Always ☐Sometimes ☐Rarely ☐Never

   Does the repellent contain DEET (N, N-diethyl-meta-toluamide, or N, Ndiethyl-3-methylbenzamide), Picaridin, or Oil of Lemon Eucalyptus? ☐Yes ☐No ☐Unknown

6. During the two weeks before onset did the patient travel outside the county of residence?

   ☐Yes ☐No ☐Unknown If yes, specify when and where: ____

7. Has the patient traveled outside of New Hampshire in the two weeks prior to onset? Yes No Unknown

   If yes, specify when and where: ____

8. Has the patient traveled outside the U.S. in the two weeks prior to onset? Yes No Unknown

   If yes, specify when and where: ____

9. Does the patient have any underlying medical conditions? Yes No Unknown

   If yes, specify: ____

10. What is the patient's occupation? ____

BLOOD DONATION/TRANSFUSION/TRANSPLANT HISTORY/PREGNANCY

11. Has the patient received an organ transplant or blood product transfusion in the month prior to onset?

    Yes No Unknown

    If yes, specify when and where: ____

12. Has patient donated blood products or been a living organ donor in the one month prior to onset? ☐Yes ☐No ☐Unknown

13. Is the patient currently pregnant? ☐Yes ☐No ☐Unknown ☐Not applicable

    If yes, weeks pregnant______ due date____/____/____

14. Is the patient breastfeeding or planning to breastfeed? ☐Yes ☐No ☐Unknown

COMMENTS: ____

____

REPORTED BY: **DATE OF REPORT:** ____/____/____

Last Name________________________First Name____________________Title(ICN, Resident, Attending)___________________

Work address__________________________________City__________________________State_______Zip Code____________

Phone____Pager___________________________________

FOR DHHS USE:

Initial Report Taken by:____ Report Completed by:______________________________

Case Status: ☐Confirmed ☐Probable ☐Not a Case ☐Unknown ☐Other State