

Encephalitis Case History Form

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

*By sending specimens to the California Encephalitis Project (CEP),
you authorize CEP to initiate additional testing as patient history or clinical information indicates.*

Case patients must be **hospitalized** with encephalopathy (depressed or altered level of consciousness \geq 24 hours, lethargy, or change in personality) or ataxia, **AND** have 1 or more of the following: fever ($T \geq 38C$), seizure(s), focal neurologic findings, CSF pleocytosis, abnormal EEG or neuroimaging study. **Case patients must be \geq 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 Arthropod contact: No Yes Details: _____

Immunization in last month: No Yes Details: _____

Medications (including OTC and herbal): No Yes Details: _____

Outdoor activity (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)

Hypertension: No Yes _____ Diabetes: No Yes (if yes, what type? Insulin dependent?) _____

Other PMH: _____

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

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

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

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

In ICU No Yes Date: ____/____/____

Intubated No Yes Date: ____/____/____

Fever ≥ 38° 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 _____

Movement Disorder No Yes _____

Autonomic instability 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 _____

CSF results (first available and subsequent)

Date ____/____/____

OP _____

RBC _____

WBC _____

Diff ____/____/____
(seg/lymph/mono/eos) (seg/lymph/mono/eos)

Protein _____

Glucose _____

CrAg _____

VDRL _____

Blood Glucose _____

HSV PCR on CSF performed at hospital/commercial lab?

No Yes Result: NEG POS

Date of LP ____/____/____

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 ____/____/____

Steroids/IVIG ____/____/____

Antibacterial agents ____/____/____

REQUIRED: Contact physician information (MANDATORY - FOR RELAYING RESULTS)

Name _____ Pager (____) _____ Fax (____) _____ E-mail _____

Facility _____ City _____

Primary Care Physician Name _____ Pager (____) _____ Fax (____) _____

For questions regarding Project or specimen requirements, contact Heather Sheriff at 510-307-8608. Fax this form to 510-307-8599 or send with specimens to Attn: Specimen Receiving/California Encephalitis Project -- 850 Marina Bay Parkway, Richmond, CA 94804