

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: _____

Glascow 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 ____/____/____ Antibacterial agents ____/____/____
 Steroids/IVIG ____/____/____

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 Shilpa Gavali 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