New Hampshire Case Report Arboviral Infection Encephalitis/Meningitis	**This form must be faxed to the New Hampshire Communicable Disease Control Section (603-271-0545) *and* a copy submitted with the laboratory specimen(s) to the NH Public Health Laboratories**

Prior to submission of suspect Chikungunya virus specimens for testing, a Public Health Nurse at the Bureau of Infectious Disease Control must be consulted in order to avoid a testing fee.
Please indicate the nurse contacted for tracking purposes: _____

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 °F	☐	☐	☐	Disorientation	☐	☐	☐	Convulsions	☐	☐	☐
Highest Temp (if known)	_____ °F			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 If Yes, list below. **Date Started**

_____ ___/___/___

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

Patient Name: _____ **DOB:** ___/___/____

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