

**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 $\geq 100^{\circ}\text{F}$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Highest Temp (if known) _____ <sup>o</sup> F				Delirium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis/Paresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lethargy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acute Flaccid Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stupor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cranial Nerve Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location of Rash			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperreflexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rigidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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