

# Viral Encephalitis/Meningitis History

New York State Department of Health  
 Wadsworth Center, Empire State Plaza  
 Viral Encephalitis Laboratory  
 P.O. Box 509  
 Albany, New York 12201-0509  
 Phone (518) 869-4557

\* Please see instructions for shipping address

NYS Lab Number

Date Received

Please type or print legibly in black ink

Patient

Specimen

Last Name		First Name		MI	DOB MM / DD / YY	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City/State		Zip Code	County of Residence	
Telephone ( ) _____-_____		Occupation		Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other
<input type="checkbox"/> CSF Date Collected MM / DD / YY Submitter Specimen ID _____		<input type="checkbox"/> Serum Date Collected MM / DD / YY Submitter Specimen ID _____		<input type="checkbox"/> Other _____ Date Collected MM / DD / YY Submitter Specimen ID _____		Onset Date MM / DD / YY

<b>Requesting Medical Provider Name and Address</b> Wadsworth laboratory results will be sent to:  Please provide the name and telephone number of the person we may contact with questions: <b>Contact person</b> _____ <b>Email</b> _____ <b>Telephone</b> _____ <b>Fax</b> _____	<b>Laboratory PFI</b> _____
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**Comments**

\_\_\_\_\_

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Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide hospital name	
Hospital street address	City _____	State _____ Zip _____
Medical record #	Date of Admission ____/____/____	Date of discharge/transfer ____/____/____

**CLINICAL INFORMATION**

**Current Diagnosis :**  encephalitis  meningitis  other diagnosis (specify) \_\_\_\_\_

**Pregnant**  Yes  No  Unknown If yes, please list gestational week at onset of symptoms \_\_\_\_\_

**Signs/Symptoms (Please check)**

Fever ( $\geq 100.4^{\circ}\text{F}$ ) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Altered mental status <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Stiff neck/Meningeal signs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Muscle weakness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Muscle pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other _____	Outcome <input type="checkbox"/> Recovered <input type="checkbox"/> Died <input type="checkbox"/> Unknown
<b>If patient died, date of death</b> ____/____/____	Autopsy performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Received 4 weeks prior to first symptom:  transfusion  transplant

Donated 4 weeks prior to first symptom:  blood/blood products  organ

**Risk Factor Information:** (during month preceding onset)

**Patient traveled:**  Outside country  Outside New York State  Outside county of residence

**Animal or arthropod contact?**  Yes  No  Unknown Specify: \_\_\_\_\_

**LABORATORY INFORMATION/TEST RESULTS** (Please specify units when applicable.)

**CSF** Test Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Glu \_\_\_\_\_ Prot \_\_\_\_\_ RBC \_\_\_\_\_ WBC \_\_\_\_\_ Diff: Segs% \_\_\_\_\_ Lymphs % \_\_\_\_\_  
 Gram stain \_\_\_\_\_ Bacterial Culture \_\_\_\_\_ Fungal/Parasitic tests \_\_\_\_\_  
 Viral test results (Culture/Serology/PCR) \_\_\_\_\_

**CBC** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Abnormal?  Yes  No  Unknown  
 WBC \_\_\_\_\_ Diff: Segs% \_\_\_\_\_ Lymphs% \_\_\_\_\_ Bacterial Culture \_\_\_\_\_

**MRI** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Abnormal?  Yes  No  Unknown Result \_\_\_\_\_

**CT** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Abnormal?  Yes  No  Unknown Result \_\_\_\_\_

**EEG** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Abnormal?  Yes  No  Unknown Result \_\_\_\_\_

**EMG** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Abnormal?  Yes  No  Unknown Result \_\_\_\_\_

Antiviral Treatment  Yes  No  Unknown. If yes, list below \_\_\_\_\_

Date started:

\_\_\_\_/\_\_\_\_/\_\_\_\_