

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

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	

Specimen

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	

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

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
If patient died, date of death _____/_____/_____	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: _____