NC Electronic Disease Surveillance System
North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

ENCÉPHALITIS, ARBOVIRAL, OTHER
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 98

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient’s Last Name First Middle Suffix Maiden/Other Alias

NC EDSS LAB RESULTS
Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date Specimen # Specimen Source Type of Test Test Result(s) Description (comments) Result Date Lab Name—City/State

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE

CLINICAL FINDINGS
EEG performed ........................................... □ Y □ N □ U
Date performed (mm/dd/yyyy): ___/___/___
Result: ...................................................

EMG performed ........................................... □ Y □ N □ U
Date performed (mm/dd/yyyy): ___/___/___
Result: ...................................................

Head CT performed .................................... □ Y □ N □ U
Date performed (mm/dd/yyyy): ___/___/___
Result: ...................................................

MRI performed .......................................... □ Y □ N □ U
Date performed (mm/dd/yyyy): ___/___/___
Result: ...................................................

Other symptoms, signs, clinical findings, or complications consistent with this illness ........................................... □ Y □ N □ U
Specify: ...................................................

REASON FOR TESTING
Why was the patient tested for this condition?
□ Symptomatic of disease
□ Screening of asymptomatic person with reported risk factor(s)
□ Screening of asymptomatic person with no risk factor(s)
□ Blood / organ / tissue donor screening
□ Other ____________________________
□ Unknown

PREGNANCY
Is the patient currently pregnant? □ Y □ N □ U
Estimated delivery date (mm/dd/yyyy): ___/___/___
Is the patient a post-partum mother (≤ 6 weeks)? □ Y □ N □ U
Did patient experience onset of symptoms within 6 weeks of delivery? □ Y □ N □ U

MATERNAL INFORMATION
Was the child breastfed? □ Y □ N □ U
Did the biologic mother ever have evidence of serological IgG immunity? □ Y □ N □ U
Test date (mm/dd/yyyy): ___/___/___
Result: □ Positive □ Negative □ Equivocal □ Unknown
### Clinical Outcomes

**Discharge/Final diagnosis:**

- **Survived?**�
- **Status at time of report:**
  - Fully recovered
  - Survived but experiencing sequelae (residual deficit from illness) at time of report
- **Died?**�
- **Died from this illness?**�
- **Date of death (mm/dd/yyyy):**

### Travel/Immigration

- **The patient is:**
  - Resident of NC
  - Resident of another state or US territory
  - Foreign Visitor
  - Refugee
  - Recent Immigrant
  - Foreign Adoptee
  - None of the above
- **Did patient have a travel history during the 15 days prior to onset?**�
- **List travel dates and destinations:**

### Vector Exposures

- **During the 15 days prior to onset, did the patient have an opportunity for exposure to mosquitoes?**�
- **Exposed on (mm/dd/yyyy):**
- **Until (mm/dd/yyyy):**
- **Frequency:**
  - Once
  - Multiple times within this time period
  - Daily
- **City/county of exposure**
- **State of exposure**
- **Country of exposure**

### Vaccine

- **Has patient/contact ever received vaccine related to this disease?**�
- **Vaccine type**
- **Date of administration (mm/dd/yyyy):**
- **Source of this vaccine information**
- **How many days prior to illness onset was vaccine received?**
  - Fewer than 14 days
  - 14 days or more
  - Vaccine date unknown
  - Yes�
  - No

### Case Interviews/Investigations

- **Was the patient interviewed?**�
- **Date of interview (mm/dd/yyyy):**
- **Medical records reviewed (including telephone review with provider/office staff)?**�
- **Specify reason if medical records were not reviewed:**

### Health Care Facility and Blood & Body Fluid Exposure Risks

- **During the 15 days prior to onset, did the patient have any of the following health care exposures?**
  - Blood or blood products (transfusion) - recipient
  - Donated ova, sperm, organ, tissue, or bone marrow
  - Transplant recipient (tissue/organ/bone marrow)
  - No
  - Unknown
- **Type of donation/transplant**
- **Date received (mm/dd/yyyy):**
- **Until date (mm/dd/yyyy):**
- **Frequency:**
  - Once
  - Multiple times within this time period
  - Daily
- **Facility/provider name:**
- **Contact name at facility:**
- **Address**
- **City**
- **State**
- **Country**

### Geographical Site of Exposure

- **In what geographic location was the patient MOST LIKELY exposed?**
  - Specify location:
    - In NC
    - City
    - County
    - Outside NC, but within US
    - City
    - State
    - County
    - Outside US
    - City
    - Country
    - Unknown
- **Is the patient part of an outbreak of this disease?**�

### Notes

- **Birthdate (mm/dd/yyyy):**
- **SSN:**
- **Patient's Last Name**
- **First**
- **Middle**
- **Suffix**
- **Maiden/Other**
- **Alias**
Encephalitis or Meningitis, Arboviral (includes California serogroup, Eastern equine, St. Louis, Western equine, West Nile, Powassan)

2001 CDC Case Definition

Clinical description

Arboviral infections may be asymptomatic or may result in illnesses of variable severity sometimes associated with central nervous system (CNS) involvement. When the CNS is affected, clinical syndromes ranging from febrile headache to aseptic meningitis to encephalitis may occur, and these are usually indistinguishable from similar syndromes caused by other viruses. Arboviral meningitis is characterized by fever, headache, stiff neck, and pleocytosis. Arboviral encephalitis is characterized by fever, headache, and altered mental status ranging from confusion to coma with or without additional signs of brain dysfunction (e.g., paresis or paralysis, cranial nerve palsies, sensory deficits, abnormal reflexes, generalized convulsions, and abnormal movements).

Laboratory criteria for diagnosis

- Fourfold or greater change in virus-specific serum antibody titer, OR
- Isolation of virus from or demonstration of specific viral antigen or genomic sequences in tissue, blood, cerebrospinal fluid (CSF), or other body fluid, OR
- Virus-specific immunoglobulin M (IgM) antibodies demonstrated in CSF by antibody-capture enzyme immunoassay (EIA), OR
- Virus-specific IgM antibodies demonstrated in serum by antibody-capture EIA and confirmed by demonstration of virus-specific serum immunoglobulin G (IgG) antibodies in the same or a later specimen by another serologic assay (e.g., neutralization or hemagglutination inhibition).

Case classification

Probable: an encephalitis or meningitis case occurring during a period when arboviral transmission is likely, and with the following supportive serology: 1) a single or stable (less than or equal to twofold change) but elevated titer of virus-specific serum antibodies; or 2) serum IgM antibodies detected by antibody-capture EIA but with no available results of a confirmatory test for virus-specific serum IgG antibodies in the same or a later specimen.

Confirmed: an encephalitis or meningitis case that is laboratory confirmed