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

North Carolina Public Health

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

ENCEPHALITIS, ARBOVIRAL, OTHER

Confidential Communicable Disease Report—Part 2

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	Birthdate *(mm/dd/yyyy)* / /
						SSN

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

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
Altered mental status ☐Y ☐N ☐U
Headache ☐Y ☐N ☐U
Stiff neck ☐Y ☐N ☐U
Meningitis ☐Y ☐N ☐U
Encephalitis ☐Y ☐N ☐U
Encephalomyelitis/ meningoencephalitis ☐Y ☐N ☐U
Seizures/convulsions ☐Y ☐N ☐U
Ataxia ☐Y ☐N ☐U
Gait Disturbance ☐Y ☐N ☐U
Dyscoordination ☐Y ☐N ☐U
Myoclonus ☐Y ☐N ☐U
Acute onset of peripheral neuropathy ☐Y ☐N ☐U
Muscle weakness (paresis) ☐Y ☐N ☐U
Please specify ☐Localized ☐Generalized
Muscle paralysis ☐Y ☐N ☐U
Acute flaccid paralysis ☐Y ☐N ☐U
☐Asymmetric ☐Symmetric
Respiratory paralysis ☐Y ☐N ☐U
Did patient have CSF cell count? ☐Y ☐N ☐U
Result: ☐Elevated ☐Not elevated ☐Unknown

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 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

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (_____) _____ - _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy): ____/____/____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

_____

Survived? ☐ Y ☐ N ☐ U

Status at time of report:

☐ Fully recovered

☐ Survived but experiencing sequelae (residual deficit from illness) at time of report

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): _____/_____/_____

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/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? ☐ Y ☐ N

Notes:

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? ☐ Y ☐ N ☐ U

List travel dates and destinations:

From _____/_____/_____ to _____/_____/_____

_____

_____

Additional travel/residency information:

VECTOR EXPOSURES

During the 15 days prior to onset, did the patient have an opportunity for exposure to mosquitoes? ☐ Y ☐ N ☐ U

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 _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): ____/____/____

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

VACCINE

Has patient/contact ever received vaccine related to this disease? ☐ Y ☐ N ☐ U

Vaccine type _____

☐ Unknown vaccine or immune globulin

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