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, EEE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 97

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

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