<table>
<thead>
<tr>
<th>Specimen Date</th>
<th>Specimen #</th>
<th>Specimen Source</th>
<th>Type of Test</th>
<th>Test Result(s)</th>
<th>Description (comments)</th>
<th>Result Date</th>
<th>Lab Name—City/State</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>

**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:  

**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-parturum 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
### HOSPITALIZATION INFORMATION

<table>
<thead>
<tr>
<th>Was patient hospitalized for this illness &gt;24 hours?</th>
<th>☐ Y ☐ N ☐ U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital name:</td>
<td></td>
</tr>
<tr>
<td>City, State:</td>
<td></td>
</tr>
<tr>
<td>Hospital contact name:</td>
<td></td>
</tr>
<tr>
<td>Telephone: (<strong><strong>) - (</strong></strong>)</td>
<td></td>
</tr>
<tr>
<td>Admit date (mm/dd/yyyy): <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>Discharge date (mm/dd/yyyy): <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
</tbody>
</table>

### 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): ____/____/____

### 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:

### 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:**

___________________________________

### GEOPHICAL SITE OF EXPOSURE

**In what geographic location was the patient MOST LIKELY exposed?**

☐ In NC
☐ City
☐ County
☐ Outside NC, but within US
☐ City
☐ State
☐ County
☐ Outside US
☐ City
☐ Country

**Is the patient part of an outbreak of this disease?** ☐ Y ☐ N

Notes:

### 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:**

___________________________________

### VACCINE

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

**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

**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:

### 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: