COUNTY OF LOS ANGELES
DEPT. OF HEALTH SERVICES
PUBLIC HEALTH
Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone)
213-482-4856 (facsimile)
www.lapublichealth.org/acd

ENCEPHALITIS CASE HISTORY REPORT

(Do not fill out this form if West Nile case history form is completed)

Census tract: _____ VCMR ID: _____

Case patients must be **hospitalized** with encephalopathy (depressed or altered level of consciousness ≥ 24 hours, lethargy, or change in personality) or ataxia, **AND** have 1 or more of the following: fever (T≥38C), seizure(s), focal neurological findings, CSF pleocytosis, abnormal EEG or neuroimaging study. **Case patients must be ≥ 6 months of age and immunocompetent**

Patient name-last	first	middle initial	Date of Birth	Age	Sex

Address- number, street	City	State	ZIP Code

Telephone number Home ( )	Work ( )	Cell ( )

Race (check one)

☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:_____

Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

If Asian/Pacific Islander, please check one: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian ☐ Japanese ☐ Korean ☐ Laotian ☐ Samoan ☐ Vietnamese ☐ Other: _____

Occupation (give exact job) and kind of business or industry at date of onset

PRESENT ILLNESS

Date of first central nervous system symptoms	Hospitalized ☐ Yes ☐ No	Attending or consulting physician	

Medical record number	Admit date	Discharge date	Telephone number ( )	Fax number ( )

Previous hospitalization/ER visit

☐ Yes ☐ No ☐ Unknown Specify facility/dates: _____

Facility/Hospital Name

In Intensive Care Unit?

☐ Yes ☐ No ☐ Unknown Specify date started: _____

Intubated?

☐ Yes ☐ No ☐ Unknown Specify date started: _____

Check any symptoms that apply:

- ☐ Fever ≥ 38° C
- ☐ Upper respiratory infection
- ☐ Gastrointestinal illness
- ☐ Rash
- ☐ Severe headache
- ☐ Lethargy
- ☐ Confusion
- ☐ Aphasia or mutism
- ☐ Extreme irritability
- ☐ Hallucinations
- ☐ Psychosis
- ☐ Dementia
- ☐ Stiff neck
- ☐ Ataxia
- ☐ Focal neurologic
- ☐ Muscle weakness
- ☐ Cranial nerve abnormality
- ☐ Seizures
  - ☐ Intractable OR ☐ Induced coma: Start date: _____
- ☐ Coma: Start date: _____
- ☐ Other: Specify: _____

Significant past history (medical, social, family, including rheumatologic disorders, early organ failure)

TREATMENT	**Specify type**	**Date started**	Outcome
Antiviral agents			☐ Recovered
Antibacterial agents			☐ Fatal:
Steroids/IVIG			Date of Death: _____

DIAGNOSTIC TESTS *(List all tests performed and attach laboratory results.)*

NEUROLOGICAL TEST	Date of Test	Results	If Result is Abnormal, answer the following
Brain CT		☐ Normal ☐ Abnormal ☐ Not done	☐ Temporal lobe ☐ White matter demyelination ☐ Hydrocephalus ☐ Severe cerebral edema ☐ Other: _____
Brain MRI		☐ Normal ☐ Abnormal ☐ Not done	☐ Temporal lobe ☐ White matter demyelination ☐ Hydrocephalus ☐ Severe cerebral edema ☐ Other: _____
EEG		☐ Normal ☐ Abnormal ☐ Not done	☐ Diffuse slowing ☐ Temporal epileptiform activity ☐ PLEDS ☐ Other: _____

Patient name (last, first) _____ Date of Birth _____

CSF RESULTS	Date collected	WBC	Protein	Glucose	CBC RESULTS	Date collected	WBC
1st test					1st test		
2nd test					2nd test		

OTHER LABS AND XRAY	Date collected/ performed	Results		
In CSF Enterovirus		☐ Positive	☐ Negative	☐ Equivocal
HSV		☐ Positive	☐ Negative	☐ Equivocal
Zoster		☐ Positive	☐ Negative	☐ Equivocal
Influenza		☐ Positive	☐ Negative	☐ Equivocal
Chest x-ray		☐ Normal	☐ Abnormal	☐ Not done
Other (Specify)				

EPIDEMIOLOGIC RISK FACTORS (1 month before onset)

HISTORY OF TRAVEL	Date(s) of Travel	Destination (Specify city)
☐ In California (outside of LAC)		
☐ In the United States (US)		
☐ Outside of the US		
☐ Ever traveled outside of the US		

EXPOSURES	Details
☐ Animal or Arthropod contact	
☐ Immunization in last month	
☐ Outdoor activating (camping, hiking, gardening, etc)	
☐ Daycare	
☐ Other (head trauma, TB exposure, sick contacts, & medications including OTC and herbal)	

REMARKS

Investigator's name (print)	Investigator's signature	Date	Telephone number ( )
Agency name/Health District		Supervisor signature (if applicable)	

How was this information collected? ☐Case ☐Proxy If Proxy,Name(s), relationship(s) to case-patient:_____