

MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 51382 (R/4-04)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this: Not like this: Mark mistakes like this:
- 4 Print capital letters only and numbers completely inside boxes. A 2 C 3
- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY

Section 1. Demographic Information

Last Name			
First Name	MI	Phone Number	
Number & Street Address			
City	State	ZIP Code	
County	Date of Birth	Age	
Race: <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Native Hawaiian or Other Pacific Islander		Ethnicity: <input type="radio"/> White <input type="radio"/> Other/Multiracial <input type="radio"/> Unknown <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Unknown	
Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		Is Age in day/mo/yr? <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	
Occupation		Phone of Employer/School/Day Care	
Name of <input type="radio"/> Employer <input type="radio"/> School <input type="radio"/> Day Care			
Address of Employer/School/Day Care			
City	State	ZIP Code	

Section 2. Clinical Information

Symptoms (check all that apply): <input type="radio"/> Fever _____ (degrees) <input type="radio"/> Headache <input type="radio"/> Dizziness <input type="radio"/> Myalgia <input type="radio"/> Fatigue <input type="radio"/> Paralysis <input type="radio"/> Rash <input type="radio"/> Neck Stiffness <input type="radio"/> Stupor <input type="radio"/> Disorientation <input type="radio"/> Tremors <input type="radio"/> Muscle Weakness <input type="radio"/> Convulsions <input type="radio"/> Other, specify: _____	Date of Onset _____ / _____ / _____ Duration of Symptoms in Days _____ Date First Positive Specimen Collected _____ / _____ / _____ Acute Flaccid Paralysis? <input type="radio"/> Yes <input type="radio"/> No	Method of Testing Used: <input type="radio"/> Culture _____ Specimen Results: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> PCR _____ Specimen Results: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> CSF <input type="radio"/> Serology See page 2.
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MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 2 of 4

Indiana State Department of Health
State Form 51382 (R/4-04)

Section 2. Clinical Information (continued)

1. IgM Testing

____/____/____
Acute Specimen Taken

Acute Value

____/____/____
Convalescent Specimen Taken

Convalescent Value

Results:

- Significant Rise in IgM Pending
- No Significant Rise in IgM Not Done
- Indeterminate Unknown

2. IgG Testing

____/____/____
Acute Specimen Taken

Acute Value

____/____/____
Convalescent Specimen Taken

Convalescent Value

Results:

- Significant Rise in IgG Pending
- No Significant Rise in IgG Not Done
- Indeterminate Unknown

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City State ZIP Code

____ - ____ - ____
Physician/Hospital Phone

Was the patient hospitalized before or during infection?

- Yes No

If Yes, admission date: ____/____/____

Discharge date: ____/____/____

Hospital: _____

Did patient die?

- Yes No

Diagnosis:

- Encephalitis Meningitis
- Uncomplicated fever Asymptomatic infection
- Other clinical Unknown

1. Did patient receive blood or blood product within previous 30 days? Yes No

2. Did patient donate blood or blood product within previous 30 days? Yes No

3. Is the patient a Presumptive Viremic donor? Yes No ____/____/____
If Yes, donation date

4. Was patient an organ recipient or donor within previous 30 days? Yes No

5. Is patient pregnant? Yes No

6. Was the patient breast-feeding at the time of the illness? Yes No

MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 3 of 4

Indiana State Department of Health
State Form 51382 (R/4-04)

Section 3. Risk Factors

Patient's home setting:

- Urban Suburban Rural

Is the patient's home located adjacent to (check all that apply):

- Wetlands Woods Marsh/Bog Dumps
- Streams Ponds Sewage/Septic Effluent Other Area(s) of Standing Water

Are any of the following water containers located outside of the home or area (check all that apply)?

- Birdbaths Fountains Used Tires
- Garden Ponds Pools
- Other Containers, specify: _____

Does home have working screens for windows and doors?

- Yes No

During the two weeks prior to symptoms, did the patient:

Engage in outdoor activities at home?

- Yes No

If Yes, describe

____ / ____ / ____

Date

Engage in the following activities (check all that apply)?

- Camping Hiking Fishing Picnicking

If so, where

____ / ____ / ____

Date

Travel to recreational areas within county of residence?

- Yes No

If Yes, where

____ / ____ / ____

Date:

Travel outside of county of residence but within Indiana?

- Yes No

If Yes, where

____ / ____ / ____

Date

Travel outside of Indiana?

- Yes No

If Yes, where

____ / ____ / ____

Date

MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 4 of 4

Indiana State Department of Health
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Section 3. Risk Factors (Continued)

Stay overnight away from home?

Yes No

If Yes, where

____ / ____ / ____

Date

During the two weeks prior to symptoms, did the patient:

Sustain any known mosquito bites?

Yes No

____ / ____ / ____

If Yes, date:

Section 4. Diagnosis

Diagnosis:

- | | | | |
|-----------------------------|-------------------------------|--------------------------------|---------------------------------|
| Eastern Equine Encephalitis | <input type="radio"/> Suspect | <input type="radio"/> Probable | <input type="radio"/> Confirmed |
| St. Louis Encephalitis | <input type="radio"/> Suspect | <input type="radio"/> Probable | <input type="radio"/> Confirmed |
| La Crosse Encephalitis | <input type="radio"/> Suspect | <input type="radio"/> Probable | <input type="radio"/> Confirmed |
| West Nile Encephalitis | <input type="radio"/> Suspect | <input type="radio"/> Probable | <input type="radio"/> Confirmed |
| Other | <input type="radio"/> Suspect | <input type="radio"/> Probable | <input type="radio"/> Confirmed |

If Other, specify

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

____ - ____ - ____ / ____ / ____

Phone Number

Date