

Eastern Equine Encephalitis (EEE)

FOR STATE USE ONLY

Investigator: _____
Agency: _____

Phone number: _____

Status: Confirmed Suspect
 Probable Not a case
Reviewer initials: _____
Referred to another state: _____

CASE

Last name: _____
First and middle name: _____
Maiden name: _____ Suffix: _____
Address line: _____
Zip: _____ City: _____
State: _____ County: _____
Long-term care resident: Yes No Unknown
Facility name: _____
Facility phone: ()- - Type: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____
Gender: Female Male Other _____
Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____
Marital status: Single Parent with partner Widowed
 Married Separated
Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian
Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
Parent/Guardian name: _____
Parent/Guardian phone: ()- - Type: _____

EVENT

Onset date: ____ / ____ / ____ Diagnosis date: ____ / ____ / ____
Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown
Outbreak related: Yes No Unknown
Outbreak name: _____
Exposure setting: _____
Epi-linked: Yes No Unknown
Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown
State: _____ Country: _____

Healthcare provider information

Last name: _____
First name: _____
Provider type: ARNP MD
 DO NP PA
Facility name: _____
Address line 1: _____
Address line 2: _____
Zip code: _____ City: _____
State: _____ County: _____
Phone: ()- - Type: _____

LABORATORY FINDINGS

Laboratory: _____	Specimen source: _____	Test type: <input type="checkbox"/> Serology (ELISA) <input type="checkbox"/> PCR <input type="checkbox"/> Other _____
Accession #: _____	Result date: ____ / ____ / ____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final
Collection date: ____ / ____ / ____	Test type: <input type="checkbox"/> Acute <input type="checkbox"/> IgM <input type="checkbox"/> Convalescent <input type="checkbox"/> IgG	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Date received: ____ / ____ / ____	Organism: Eastern Equine virus	Type: _____

Laboratory: _____	Specimen source: _____	Test type: <input type="checkbox"/> Serology (ELISA) <input type="checkbox"/> PCR <input type="checkbox"/> Other _____
Accession #: _____	Result date: ____ / ____ / ____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final
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Date received: ____ / ____ / ____	Organism: Eastern Equine virus	Type: _____

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Accession #: _____	Result date: ____ / ____ / ____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final
Collection date: ____ / ____ / ____	Test type: <input type="checkbox"/> Acute <input type="checkbox"/> IgM <input type="checkbox"/> Convalescent <input type="checkbox"/> IgG	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Date received: ____ / ____ / ____	Organism: Eastern Equine virus	Type: _____

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: _____ Job title: _____
 Worked after symptom onset: Yes No Unknown Facility name: _____
 Date worked from: ____/____/____ Address: _____
 Date worked to: ____/____/____ Zip code: _____
 Removed from duties: Yes No Unknown City: _____ State: _____ County: _____
 Date removed: ____/____/____ Phone: (____)____-____-____ Type: _____
 Handle food: Yes No Unknown
 Attend or provide child care: Yes No Unknown
 Attend school: Yes No Unknown
 Work in a lab setting: Yes No Unknown
 Work in a health care setting: Yes No Unknown
 Direct patient care duties: Yes No Unknown
 Health care worker type: _____

Occupation type: _____ Job title: _____
 Worked after symptom onset: Yes No Unknown Facility name: _____
 Date worked from: ____/____/____ Address: _____
 Date worked to: ____/____/____ Zip code: _____
 Removed from duties: Yes No Unknown City: _____ State: _____ County: _____
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 Handle food: Yes No Unknown
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 Work in a lab setting: Yes No Unknown
 Work in a health care setting: Yes No Unknown
 Direct patient care duties: Yes No Unknown
 Health care worker type: _____

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____ Isolated at entry: Yes No Unk Isolation type (entry): _____
 Admission date: ____/____/____ Discharge date: ____/____/____ Days hospitalized: _____
 Currently isolated: Yes No Unk Current isolation type: _____

CLINICAL INFO & DIAGNOSIS

Physician diagnosis: Encephalitis Asymptomatic Dengue hemorrhagic fever/ Dengue shock **Clinical classification:** Neuroinvasive Non-neuroinvasive
 Meningitis Hepatitis/jaundice
 Meningoencephalitis Multi-system organ failure
 Fever Other _____
Symptoms: Acute flaccid paralysis Diarrhea Headache Stiff neck
 Altered mental state Double vision Joint pain Swollen lymph nodes
 Anorexia Eye pain Muscle pain Tremors
 Coma Fatigue Nausea Vertigo
 Confusion Fever Photophobia Vomiting
 Cranial nerve palsies Gait/balance difficulty Rash Other symptoms: _____

Pre-existing Conditions

Before your West Nile virus (WNV) infection, did a health care provider ever tell he/she had any of the following medical conditions?

Diabetes Congestive heart failure Kidney disease or failure
 High blood pressure (hypertension) Stroke Bone marrow transplant
 Heart attack (myocardial infarction) Chronic obstructive pulmonary disease (COPD) Alcoholism
 Angina or coronary artery disease Chronic liver disease Case had none of the conditions listed

Before WNV infection, did the case ever have a solid organ transplant? Yes No Unk

If yes, what organ was transplanted: _____

If yes, what year was the transplant: _____

Before WNV infection, has the case ever had cancer? Yes No Unk

If yes, what cancer type(s): _____

If yes, what year were you diagnosed: _____

If yes, are you currently being treated for cancer: Yes No Unk

Before WNV infection, did the case have any medical condition that limited his/her ability to fight infection? Yes No Unk

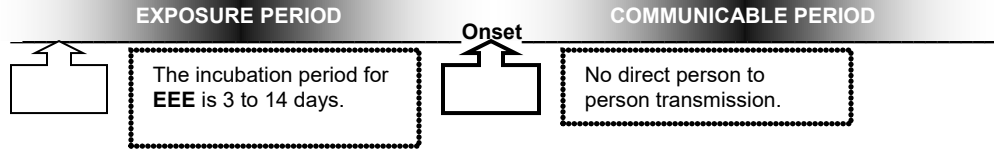
If yes, what condition: _____

At the time WNV infection was diagnosed, was the case taking any of the following types of prescription medications or treatments?

- Chemotherapy, Oral or injected steroids, Medications to treat coronary artery disease, Other treatments for cancer, Inhaled steroids, Medications to treat congestive heart failure, Hemodialysis, Insulin or other medications to treat diabetes, Medications that suppress the immune system, Other treatments for kidney disease, Medications to treat high blood pressure, Case was not on any medication/treatments listed

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Ever vaccinated for Yellow Fever or Japanese encephalitis (JE)? Yes No Unknown

If yes, list MOST RECENT vaccination information ONLY:

Two columns of vaccination information forms. Each includes fields for Disease (Yellow fever, JE), Date vaccinated, Lot #, Vaccine type, and Manufacturer.

Number of vaccinations: _____

Risk Factors/Travel Information

In the 15 days prior to onset of symptoms did the case:

Travel information form with sections for 'Traveled within Iowa?', 'Traveled within U.S.?', and 'Traveled outside U.S.?' including fields for City, State, Country, and Departure/Return dates.

Exposed to mosquitoes: Yes No Unk

Use a mosquito repellent: Yes No Unk. If yes, how often? Sometimes Never Always Most of the time. If yes, what type? Picaridin DEET Oil of lemon eucalyptus Other _____

If the patient is female, was she:

Pregnant? Yes No Unk
Breastfeeding? Yes No Unk

In the 30 days prior to onset of symptoms did the case:

30-day prior information form including 'Donate blood, blood products, organs or tissues?', 'Receive blood or blood products?', 'Receive organs or tissue?', and 'Case acquired infection?' with various sub-options.

NOTES:

Horizontal lines for handwritten notes.