

St. Louis Encephalitis (SLE)

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: Serology (ELISA)
 PCR Other _____
 Accession #: _____ Result date: ____ / ____ / ____ Result type: Preliminary Final
 Collection date: ____ / ____ / ____ Test type: Acute IgM
 Convalescent IgG Result: Negative Equivocal
 Positive Indeterminate
 Date received: ____ / ____ / ____ Organism: **St. Louis virus** Type: _____

Laboratory: _____ Specimen source: _____ Test type: Serology (ELISA)
 PCR Other _____
 Accession #: _____ Result date: ____ / ____ / ____ Result type: Preliminary Final
 Collection date: ____ / ____ / ____ Test type: Acute IgM
 Convalescent IgG Result: Negative Equivocal
 Positive Indeterminate
 Date received: ____ / ____ / ____ Organism: **St. Louis virus** Type: _____

Laboratory: _____ Specimen source: _____ Test type: Serology (ELISA)
 PCR Other _____
 Accession #: _____ Result date: ____ / ____ / ____ Result type: Preliminary Final
 Collection date: ____ / ____ / ____ Test type: Acute IgM
 Convalescent IgG Result: Negative Equivocal
 Positive Indeterminate
 Date received: ____ / ____ / ____ Organism: **St. Louis 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: _____
 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: _____

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

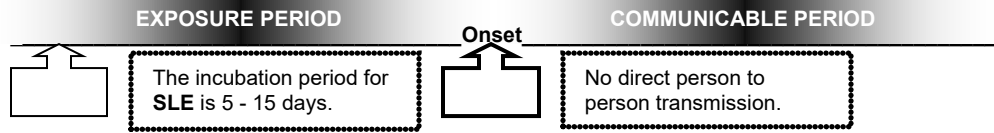
If yes, what condition: _____

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:

Disease: Yellow fever
 JE

Disease: Yellow fever
 JE

Date vaccinated: ____ / ____ / ____

Date vaccinated: ____ / ____ / ____

Lot #: _____

Lot #: _____

Vaccine type: _____

Vaccine type: _____

Manufacturer: _____

Manufacturer: _____

Number of vaccinations: _____

Risk Factors/Travel Information

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

Traveled within Iowa? Yes No Unk City in Iowa: _____

Traveled within U.S.? Yes No Unk State: _____ City: _____

Traveled outside U.S.? Yes No Unk Country: _____

Departure date: ____ / ____ / ____ Return date: ____ / ____ / ____

Departure date: ____ / ____ / ____ Return date: ____ / ____ / ____

Departure date: ____ / ____ / ____ Return date: ____ / ____ / ____

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:

Donate blood, blood products, organs or tissues? Yes No Unk

Date donated: ____ / ____ / ____

Receive blood or blood products? Yes No Unk

Date received: ____ / ____ / ____

Receive organs or tissue? Yes No Unk

Date received: ____ / ____ / ____

Case acquired infection:

- Naturally
- Transplantation
- Transfusion
- Trans-placental
- Breastfeeding
- Occupationally
- Unknown

NOTES:
