**ATTENTION HEALTH CARE PROVIDERS:**
Please report relevant clinical findings about this disease event to the local health department.

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**NC EDSS EVENT ID#**

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**ENCÉPHALITIS, ARBOVIRAL, EEE**
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 97

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**REMARKS**
To Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

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**LAB RESULTS**
Verify if lab results for this event are in NC EDSS. If not present, enter results.

**NC EDSS PART 2 WIZARD**
COMMUNICABLE DISEASE

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**CLINICAL FINDINGS**

<table>
<thead>
<tr>
<th>EEG performed</th>
<th>EMG performed</th>
<th>Head CT performed</th>
<th>MRI performed</th>
<th>Other symptoms, signs, clinical findings, or complications consistent with this illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y  N  U</td>
<td>Y  N  U</td>
<td>Y  N  U</td>
<td>Y  N  U</td>
<td>Y  N  U</td>
</tr>
</tbody>
</table>

**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)

**PREGNANCY**

Is the patient currently pregnant? Y  N  U
Estimated delivery date (mm/dd/yyyy): ____/____/____

Is patient a post-partum 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): ____/____/____

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**NC Electronic Disease Surveillance System**
Division of Public Health • Epidemiology Section
Communicable Disease Branch

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**North Carolina Department of Health and Human Services**
NC  EDSS EVENT ID#
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

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____________________________________________

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 _________________________________________________________

VECTOR EXPOSURES

During the 15 days prior to onset, did the patient have a travel history during the 15 days prior to onset? ............................................. Y N U

List travel dates and destinations:

From ______/____/____ to ______/____/____

GEOGRAHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location: __________________________________________________
- In NC
- City __________________________________________________________
- County _______________________________________________________
Encephalitis or Meningitis, Arboviral (includes California serogroup, Eastern equine, St. Louis, Western equine, West Nile, Powassan)

2001 CDC Case Definition

Clinical description

Arboviral infections may be asymptomatic or may result in illnesses of variable severity sometimes associated with central nervous system (CNS) involvement. When the CNS is affected, clinical syndromes ranging from febrile headache to aseptic meningitis to encephalitis may occur, and these are usually indistinguishable from similar syndromes caused by other viruses. Arboviral meningitis is characterized by fever, headache, stiff neck, and pleocytosis. Arboviral encephalitis is characterized by fever, headache, and altered mental status ranging from confusion to coma with or without additional signs of brain dysfunction (e.g., paresis or paralysis, cranial nerve palsies, sensory deficits, abnormal reflexes, generalized convulsions, and abnormal movements).

Laboratory criteria for diagnosis

- Fourfold or greater change in virus-specific serum antibody titer, OR
- Isolation of virus from or demonstration of specific viral antigen or genomic sequences in tissue, blood, cerebrospinal fluid (CSF), or other body fluid, OR
- Virus-specific immunoglobulin M (IgM) antibodies demonstrated in CSF by antibody-capture enzyme immunoassay (EIA), OR
- Virus-specific IgM antibodies demonstrated in serum by antibody-capture EIA and confirmed by demonstration of virus-specific serum immunoglobulin G (IgG) antibodies in the same or a later specimen by another serologic assay (e.g., neutralization or hemagglutination inhibition).

Case classification

Probable: an encephalitis or meningitis case occurring during a period when arboviral transmission is likely, and with the following supportive serology: 1) a single or stable (less than or equal to twofold change) but elevated titer of virus-specific serum antibodies; or 2) serum IgM antibodies detected by antibody-capture EIA but with no available results of a confirmatory test for virus-specific serum IgG antibodies in the same or a later specimen.

Confirmed: an encephalitis or meningitis case that is laboratory confirmed