Encephalitis, Post Influenza Infection Extended Case Report Form (FL Disease Code 48780)

REPORTING CRITERIA (Must fulfill all of the following):

☐ **Presence of: Encephalopathy (altered mental status with or without seizures, or personality change, of duration >24 hours)**
☐ **Onset of encephalopathy/seizures within 5 days of acute febrile illness**
☐ **Laboratory or rapid diagnostic test evidence of acute influenza virus infection**

IF ANY OF THE ABOVE CRITERIA ARE NOT MET, STOP (DO NOT REPORT THE CASE)

Patient Demographics

1. State:	2. County:	3. Merlin Case ID:	4. CDC ID:
5. Age: _____ ☐ Days ☐ Months ☐ Years	6. Date of birth: _____/ _____/ _____ MM DD YYYY	7.Sex: ☐ Male ☐ Female	8. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

9. Race: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown

Illness Information

10. Date of illness onset: _____/ _____/ _____ MM DD YYYY	11. Date of first neurological symptoms: _____/ _____/ _____ MM DD YYYY	12. What was the duration of altered mental status? _____ days

13. Did the patient have a seizure?……. ☐ Yes ☐ No

IF YES

13b. Did the patient have a single seizure or multiple seizures?…….. ☐ Single ☐ Multiple
13c. Was the patient admitted for status epilepticus?…….. ☐ Yes ☐ No
13d. Did the patient ever have seizures with a fever before (febrile seizures)?…… ☐ Yes ☐ No
13e. Did the patient have a seizure disorder not related to fevers (epilepsy)?…….. ☐ Yes ☐ No
13f. Approximately how long did the longest seizure last (specify time in minutes or hours): _____
13g. Did the patient receive anti-seizure medications?……..☐ Yes ☐ No
13h. Was the patient placed into a medication-induced coma for seizure control?…...☐ Yes ☐ No
13i. Was a Glasgow Coma Score on admission available? ☐Yes ☐ No If YES, list GCS score: _____

Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
☐ Commercial rapid antigen test	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B (Not Distinguished)	_____/ _____/ _____
☐ Viral culture	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)	_____/ _____/ _____
☐ Direct fluorescent antibody (DFA)	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B	_____/ _____/ _____
☐ Indirect fluorescent antibody (IFA)	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B	_____/ _____/ _____
☐ Enzyme immunoassay (EIA)	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)	_____/ _____/ _____
☐ RT-PCR	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)	_____/ _____/ _____
☐ Immunohistochemistry (IHC)	☐ Influenza A ☐ Influenza B ☐ Negative	_____/ _____/ _____

Culture confirmation of secondary INVASIVE bacterial pathogens

14. Was an INVASIVE bacterial infection confirmed by culturing an organism from a specimen collected from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? ☐ Yes ☐ No

☐ *Streptococcus pneumoniae*	☐ *Staphylococcus aureus,* methicillin **sensitive**	☐ *Neisseria meningitidis (serogroup, if known):*_____

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☐ *Haemophilus influenzae* type b	☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**	☐ Group A streptococcus
☐ *Haemophilus influenzae* not-type b	☐ *Staphylococcus aureus,* **sensitivity not done**	☐ Other invasive bacteria: _____

Medical Care

15. Did the patient receive medical care for this illness? ☐ Yes* ☐ No

16. **If YES*,** indicate level(s) of care received (check all that apply): ☐ Outpatient clinic ☐ ER ☐ Inpatient ward ☐ ICU

17. Did the patient require mechanical ventilation? ☐ Yes ☐ No

Clinical Diagnoses and Complications

18. **Check all complications that occurred during the acute illness:** ☐ **NONE**

☐ Pneumonia (Chest X-Ray confirmed) ☐ Acute Respiratory Disease Syndrome (ARDS) ☐ Croup ☐ Reye syndrome
☐ Bronchiolitis ☐ Shock ☐ Another viral co-infection: _____

☐ Nuchal rigidity ☐ Bulging fontanelle ☐ Papilledema ☐ Coma
☐ Ataxia/instability, loss of balance ☐ Primitive reflexes (e.g. Babinski)

☐ Behaviroal/physiatric symptoms Describe……...
☐ Focal neurological deficit Describe……...
☐ Cranial nerve abnormality Describe……...
☐ Movement disorder Describe……...
☐ Other neurological observations (describe):
_____

19. **Check all medical conditions that existed before the start of the acute illness:** ☐ **NONE**

☐ Moderate to severe developmental delay ☐ Hemaglobinopathy (e.g. sickle cell disease) ☐ Asthma/ reactive airway disease
☐ Diabetes mellitus ☐ History of febrile seizures ☐ Seizure disorder ☐ Cystic fibrosis
☐ Cardiac disease (specify) _____ ☐ Renal disease (specify) _____
☐ Chronic pulmonary disease (specify) _____ ☐ Immunosuppressive condition (specify) _____
☐ Metabolic disorder (specify) _____ ☐ Neuromuscular disorder (including cerebral palsy) (specify) _____
☐ Pregnant (specify gestational age) _____ weeks ☐ Other (specify) _____

Medication and Therapy History

20. Was the patient receiving any of the following therapies prior to illness onset? **(check all that apply)**

☐ Aspirin or aspirin-containing products ☐ Steroids taken by mouth or injection ☐ Chemotherapy treatment for cancer ☐ Radiation therapy ☐ Any other immunosuppressive therapy: _____

Influenza vaccine history

21. Did the patient receive any influenza vaccine during the current season (before illness) ☐ Yes* ☐ No

22. **If YES*,** please specify influenza vaccine received before illness onset: ☐ Trivalent inactivated influenza vaccine (TIV) *[injected]*
☐ Live-attenuated influenza vaccine (LAIV) *[nasal spray]*

23. **If YES***, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

☐ 1 dose **ONLY**	☐ <14 days prior to illness onset ☐ ≥14 days prior to illness onset	Date dose given:_____/ _____/_____ MM DD YYYY	
☐ 2 doses	☐ 2nd dose given <14 days prior to onset ☐ 2nd dose given ≥14 days prior to onset	Date of 1st dose: _____/ _____/_____ MM DD YYYY	Date of 2nd dose: _____/ _____/ _____ MM DD YYYY

24. Did the patient receive any influenza vaccine in previous seasons? ☐ Yes ☐ No ☐ Unknown

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Neuroimaging and Neurodiagnostic testing (Complete all that apply below and please send a copy of all reports)

25. Was a Head CT done? ☐ Yes ☐ No

25b. If YES, check all that apply: ☐ Contrast ☐ Non Contrast ☐ Normal ☐ Abnormal ☐ Date of CT: ____/_____/_____

25c. If Abnormal, specify: _____

26. Was a Brain MRI done? ☐ Yes ☐ No

26b. If YES, check all that apply: ☐ Normal ☐ Abnormal ☐ Date of MRI: ____/_____/_____

26c. If Abnormal, specify: _____

27. Was an Electroencephalogram (EEG) done? ☐ Yes ☐ No

27b. If YES, check all that apply: ☐ Normal ☐ Abnormal ☐ Date of EEG: ____/_____/_____

27c. If Abnormal, specify: _____

Additional information:

Cerebrospinal fluid (CSF) results

28. Was CSF obtained? ☐ Yes ☐ No If YES, Date CSF obtained: ____/_____/_____

28b. If YES, please complete all of the following:

CSF WBC: _____/mm^3 CSF % PMN: _____ CSF % Lymph: _____ CSF RBC: _____/mm^3

CSF Protein: _____mg/dL CSF Glucose: _____mg/dL CSF Gram Stain result: _____

29. If CSF was obtained, was CSF from this patient sent to State Laboratory? ☐ Yes ☐ No

Admission laboratory results

WBC: _____ % Neutrophils: _____ % Bands: _____ % Lymphocytes: _____ % Platelets: _____

Sodium: _____ Potassiume: _____ Bicarbonate: _____ Glucose: _____ BUN: _____ Creatinine: _____

Toxicology screen results (if done): _____ Salicylate level (if done): _____

Other lab results during illness (highest values recorded)

Ammonia: _____ AST (SGOT): _____ ALT (SGPT): _____ %LDH: _____ %CPK: _____

Neurologic outcome of illness at discharge from medical facility (check one)

☐ Alive, no neurologic sequelae ☐ Alive, neurologic sequelae present ☐ Died

If neurologic sequelae at discharge, (describe): _____

_____

Discharge diagnosis (list all)

_____ _____ _____ _____

_____ _____ _____ _____

PLEASE PROVIDE: Clinical Discharge Summary (include admission history and exam), Laboratory results, CT, MRI, and EEG reports.

Submitted By: _____

Phone No.: (_____)_____ Date: _____/ _____/ _____
MM DD YYYY

Email address: _____

PLEASE FAX COPIES OF THIS FORM TO 850-414-6894