# Viral/Aseptic Meningitis/Encephalitis/Meningoencephalitis Report Form

**If you have any questions concerning the information requested on this form, please contact the Office of Epidemiology at (801) 538-6191**

## Patient Information

Last Name _____ First Name _____

Date of Birth ___/___/____ Age _____ Sex ☐ Male ☐ Female **Date of Report** ___/___/___

Address _____ City _____ County _____

State _____ Zip Code _____ Telephone Home (_____)_____ Work (_____)_____

Race ☐ White ☐ Black ☐ Am Indian/Alaskan ☐ Asian ☐ Other ☐ Unknown Hispanic ☐ Yes ☐ No ☐ Unknown

## Clinical Information

Hospitalized? ☐ Yes ☐ No Did patient die of this illness? ☐ Yes ☐ No ☐ Unknown

Hospital Name _____ City _____ State _____

Admission Date ___/___/___ Date of Onset ___/___/___ Date of First Neurologic Symptom ___/___/___

Current Diagnosis: 9 Encephalitis 9 Meningoencephalitis 9 Meningitis (9 Viral 9 Aseptic) 9 Other _____

## Medical History

Has the patient been vaccinated for or had a prior history of:

☐ Yellow Fever ☐ Japanese Encephalitis ☐ Dengue Fever ☐ St. Louis Encephalitis

☐ Other arbovirus or flavivirus (please specify) _____

| Specimens Collected | Date Collected | Type of Test | Result | Etiologic Agent |
|---|---|---|---|---|
| CSF | | | | |
| Serum (Acute) | | | | |
| Serum (Convalescent) | | | | |
| Other (Specify)_____ | | | | |

## Travel History

Travel during the two (2) months before onset of illness

| Date | City | State | Country |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Requesting Physician

Last Name _____ First Name _____

Work Address _____ State _____ Zip Code _____

Telephone Numbers Work (_____)_____ Cell (_____)_____ Pager (_____)_____

**Submitted by: _____ Agency: _____ Phone: (_____)_____**

**Utah Department of Health, Office of Epidemiology, PO Box 142104, Salt Lake City, Utah 84114-2104**
**Telephone: (801) 538-6191, FAX: (801) 538-9923**

**March 2005** **Date submitted to UDOH:_____**