ICMR-National Institute of Virology
भा. आ. अ. प. – राष्ट्रीय विषाणु विज्ञान संस्थान, पुणे
20-A, Dr. Ambedkar Road, Post Box No. 11, Pune, INDIA – 411001 (Phone: 020-26006390)

CASE HISTORY SHEET: ENCEPHALITIS / ACUTE ENCEPHALITIS SYNDROME

PATIENT INFORMATION

Patient Name: ..... **Age:** ..... **Sex:** Male/Female/Other/NA

Hospital Admission Date: ..... Case Registration No.: .....

Sample Type: Serum* & CSF* & EDTA Blood*/Other: _____

Date of Sample Collection: ..... Date of onset of Fever: .....

Date of onset of First Clinical Symptom: ..... Date of onset of First Neurological Symptom:.....

[*CSF, serum and whole blood (EDTA) are necessary for laboratory investigations of Encephalitis / AES cases].

Hospital Details: **Hospital Status**: Government/Private/Other

Hospital Name: ..... Doctor's Name: .....

Postal Address: ..... Doctor's Mobile No: .....

..... Doctor's Email ID: .....

Provisional / Differential Diagnosis: _____ _____ _____

Suspected Etiologies: _____ _____ _____

Demographic and Socio-economic Details:

Father's/Husband's Name: ..... Residential area: Rural/Semi-urban/ Urban

Village: ..... Tal: ..... District: ..... State: .....

Education: Patient: ..... Father: ..... Mother: .....

Occupation: Patient: ..... Father: ..... Mother: .....

Family Income/month: ..... Mobile no.: .....

Immediate Past History within 4 weeks of hospitalization: **[Please tick (√) whichever is applicable]**

Recent Illness: Yes / No; if yes, **Type of illness**: .....

Recent vaccination: Yes / No, if yes, **Vaccine and date:** .....

Domestic Animal Exposure: Yes / No **Animal / insect bite**: Yes / No; If yes**, details**: .....

Recent Head Injury: Yes / No **Immuno-compromized**: Yes / No **Alcoholism:** Yes / No **Smoking:** Yes / No

Recent Blood Transfusion / Organ Transplant: Yes / No; If yes, **Date and type**: .....

Contact with Patient having Similar Symptoms: Yes / No; If yes, **details:**.....

Recent Travel: Yes/No; if yes, **Date and Area of Travel**: .....

Any other information: .....

Past/Current morbidities:

Cancer/Tumor: Yes / No; Type:_____ **Autoimmune disease**: Yes / No; Type_____

Asthma: Yes / No **Hypertension:** Yes / No **Diabetes:** Yes / No **Tuberculosis:** Yes / No

Immunization History: (If vaccinated, mention year of vaccination)

JE: ☐ **Polio:** ☐ **MMR:** ☐ **Hepatitis B:** ☐ **Varicella:** ☐ **BCG:** ☐ **Others:** .....

CLINICAL SYMPTOMS

[Please tick (√) whichever is applicable]

Attach Xerox copies of case reports with history Sheet OR mail scanned copy to: encephalitisgroup2016@gmail.com

Vital basic biometrics:

Weight (kg): ..... **Body Temp**: ..... **Pulse rate**: ..... **Respiratory rate**: .....

BP Systolic: ..... **Diastolic:** ..... **Icterus:** Yes / No **Pallor:** Yes / No

Edema: Yes / No (if yes, **Generalized / Localized; Details**.....) **Facial puffiness**: Yes / No

Clinical Symptoms checklist:

(Note: **D**= Duration and **E**=Episode)

Symptoms	Observations	Symptoms	Observations
Headache	Yes / No; If yes, D: _____	**Unconscious**	Yes / No; If yes, D: _____
Cough	Yes / No	**Photophobia**	Yes / No
Dyspnea	Yes / No; If yes, D: _____	**Hydrophobia**	Yes / No
Vomiting	Yes / No; If yes, E:_____	**Phonophobia**	Yes / No
Abdomen	Tender / Non-tender	**DTR**	Yes / No
Abdominal Pain	Yes / No	**SAR**	Yes / No
Diarrhoea	Yes / No; If yes, E: _____	**Power**	
Hepatomegaly	Yes / No	**Neurological / CNS Symptoms**	
Splenomegaly	Yes / No	**Altered Sensorium**	Yes / No ; If yes, D: _____
Lymphadenopathy	Yes / No	**Seizure**	Yes / No; If yes, D & E: _____
Myocarditis	Yes / No	**Seizure Type**	Generalized/ Focal /Epileptic
Parotitis	Yes / No	**Personality changes**	Yes / No
Up Rolling of Eyeballs	Yes / No	**Mental status**	Steady/Fluctuating/Deteriorating
Pupil size		**Plantar Reflex**	Yes / No
Pupil reactive to light	Yes / No	**Neck Rigidity**	Yes / No
Dolls Eye	Yes / No	**Kernig's Signs**	Yes / No
Irritability	Yes / No	**GCS Eye**	
Hallucinations	Yes / No	**GCS Verbal**	
Frothing from Mouth	Yes / No	**GCS Motor**	
Abnormal Limb Movements	Yes / No	**GCS Total**	
Posture		**Any other signs**	

Skin/Mucous membrane Rash:

Rash: Yes / No; If yes, **Type**: Maculopapular/Erythematous/Haemorrhagic / Vesicular/ Blisters/ Nodular/ Eschar

Duration of Rash: ..... **Itching/Non-itching** **Confluent/Non-confluent**

Distribution: Generalized / Localized [Face/Neck/Trunk/Thorax/Back/Limbs (upper/lower/both)]

Radiological Investigations: [Please attach Xerox copy of investigation reports or e-mail scanned copy]

CT: Normal / abnormal **MRI:** Normal / abnormal **EEG:** Normal / abnormal

USG: Normal / abnormal **ECG:** Normal / abnormal **X -Ray:** Normal / abnormal

Details:.....

.....

Treatment Details:

[Please attach separate sheet mentioning details of drugs given to the patient along with timing and duration]

Antivirals: ..... **Antibiotics:** .....

Immunoglobulins: ..... **Steroids:** .....

Supportive treatment:.....

.....

BIOCHEMICAL INVESTIGATIONS

[Please tick (√) whichever is applicable]

Parameter	Values	Parameter	Values	Parameter	Values
Blood			**Date of collection:**		
Blood Group	_____ Rh_____	**MPV**	.....fL	**Creatinine**	.....mg/dL
Hemoglobin	.....g/dL	**ESR**	.....mm/h	**Blood urea nitrogen**	.....mg/dL
Total RBC Count	.....10^6/mm^3	**Polymorphs**	.....%	**C-reactive protein**	.....mg/L
PCV	.....%	**Lymphocytes**	.....%	**Procalcitonin**	.....µg/L
TLC (4-10.5 X 10^3/mm^3)	..... x 10^3/mm^3	**Eosinophils**	.....%	**SGOT**	.....U/L
Platelet Count (150-450 X 10^3/µl)	.....x 10^3/µl	**Basophils**	.....%	**SGPT**	.....U/L
MCV	.....pg/cell	**Monocytes**	.....%	**Glucose**	.....mg/dL
MCH	.....g/dL	**P-LCR**	.....%	**Serum Bilirubin:**	
MCHC	.....g/dL	**Transaminase**	.....IU/L	**Total:** .....mg/dL **Direct:** .....mg/dL **Indirect:** .....mg/dL	
Cerebrospinal Fluid (CSF)			**Date of collection:**		
IC Pressure	High/ low /Normal	**Appearance**	Clear / Hazy Turbid	**Blood tinged**	Yes / No
Glucose	.....mg/dL	**Proteins**	.....mg/dL	**Pleocytosis**	Yes / No
TLC	.....cells/mm^3	**Polymorphs**	.....%	**Mononuclear cells**	.....%
AFB Stain	POS / NEG /ND	**Gram Stain**	POS / NEG /ND	**Culture**	Yes / No
If yes, organism detected:					
Urine			**Date of collection:**		
Glucose	Present /Absent	**Protein**	Present/Absent	**Urine Bilirubin**	Present /Absent
C-reactive protein	.....mg/L	**Urine RBC**	.....cells/hpf	**Pus cells**	.....cells/hpf
Leukocytes	.....cells/hpf	**Urine Culture**	Yes/ No	**Organism detected:**	

Diagnostic Tests Performed at Hospital: **[POS: Positive, NEG: Negative and ND: Not Done]**

Test	Results	Test	Results	Test	Results
RDT / blood smear MP	POS/ NEG/ND	**HIV**	POS/ NEG/ND	**HSV-1 IgM**	POS/ NEG/ND
Widal	POS/ NEG/ND	**HBsAg**	POS/ NEG/ND	**JEV IgM**	POS/ NEG/ND
Blood culture	POS/ NEG/ND	**HCV**	POS/ NEG/ND	**Autoimmune disease**	POS/ NEG/ND
Tuberculosis	POS/ NEG/ND	**Dengue IgM**	POS/ NEG/ND	**Any other:** _____	
Scrub Typhus IgM	POS/ NEG/ND	**Dengue NS1**	POS/ NEG/ND	_____	

Clinical Outcome: Hospitalized / LAMA / Referred to other hospital/ Recovered/Recovered with Sequelae/Death

Date of outcome: ..... **Neurological/pathological Sequelae:** Yes / No

Sequelae Details: .....

Any other relevant information: .....

Note: ***As per the institutional practice, remaining amounts of referred specimens are archived after etiological investigations. Archived specimens may be used in research leading to development of newer diagnostics, preventive measures; generation of knowledge and evidences contributing to clinical medicine / public health with prior approval by competent authorities.***

Encephalitis Group, ICMR-National Institute of Virology, Pashan – Sus Road, Pune – 411021.