

Maryland Department of Health and Mental Hygiene
Arboviral/Encephalitis/Aseptic Meningitis Surveillance Form

PATIENT INFORMATION [or MERSS ID# (if LHD completing form): _____]

Last name: _____ First name: _____ MI: _____

Date of birth: ____/____/____ Age: _____ years / months / days Sex: Male / Female

Is patient Hispanic or Latino? RACE (Select one or more. If multiracial, select all that apply):

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> 1. Yes | <input type="checkbox"/> 1. American Indian or Alaska Native |
| <input type="checkbox"/> 2. No | <input type="checkbox"/> 2. Asian |
| <input type="checkbox"/> 3. Unknown | <input type="checkbox"/> 3. Black or African American |
| | <input type="checkbox"/> 4. Native Hawaiian or other Pacific Islander |
| | <input type="checkbox"/> 5. White |
| | <input type="checkbox"/> 6. Unknown |
| | <input type="checkbox"/> 7. Other |

Street address: _____ City: _____

County: _____ State: ____ Zip Code: _____ Phone: _____

Occupation or Setting: _____ Occupation Zip Code: _____

CLINICAL INFORMATION

Date of onset: ____/____/____ (required field) Current diagnosis? _____

Hospitalized? Yes (Hospital: _____) / No

Date of hospital admission: ____/____/____ Date of discharge: ____/____/____

Was patient transferred to another hospital? Yes (hospital: _____) / No / Unknown

Outcome: Survived / Died / Unknown Date of death: ____/____/____ Was autopsy performed? Yes / No / Unknown

LABORATORY INFORMATION

Was enteroviral testing requested? Yes / No / Unknown Was arboviral testing requested? Yes / No / Unknown

Date Collected	Date Reported	Laboratory	Test Type	Specimen	Result

Please complete the following only if patient has preliminary positive arboviral result:

ADDITIONAL CLINICAL INFORMATION

Fever ($\geq 38^{\circ}\text{C}$ or 100°F)	Yes / No / Unknown	Altered mental status	Yes / No / Unknown
Headache	Yes / No / Unknown	Stiff neck	Yes / No / Unknown
Rash	Yes / No / Unknown	Joint pain	Yes / No / Unknown
Seizures	Yes / No / Unknown	Muscle pain	Yes / No / Unknown
Diffuse muscle weakness	Yes / No / Unknown		
Other symptoms	Yes (specify: _____) / No / Unknown		

RISK FACTOR INFORMATION

Has patient traveled outside Maryland in the 2 weeks prior to onset? Yes / No / Unknown
If yes, specify when and where: _____

Has patient had known mosquito bite(s) in the 2 weeks prior to onset? Yes / No / Unknown
If yes, specify when and where (geographic location): _____

Has patient spent extended time outdoors in the 2 weeks prior to onset? Yes / No / Unknown
If yes, specify when and where: _____

Has patient received transplant or blood product transfusions in the 1 month prior to onset? Yes / No / Unknown
If yes, specify: _____

Has patient donated blood products in the 2 weeks prior to onset? Yes / No / Unknown
If yes, specify: _____

Is patient pregnant? Yes / No / Unknown / Not Applicable Weeks pregnant _____ Due date _____

VACCINE INFORMATION

Has patient received yellow fever (YF) vaccine? Yes (Date: ___/___/___) No / Unknown

Has patient received Japanese encephalitis (JE) vaccine? Yes (Date: ___/___/___) No / Unknown

Has patient received Central European encephalitis (CEE) vaccine? Yes (Date: ___/___/___) No / Unknown

REPORTING SOURCE

Name: _____ Affiliation: _____

Title: ICP / Resident / Attending / Other _____ Work address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Attending Physician (if different from above reporting source):

Name: _____ Affiliation: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____