Smt. NHL Municipal Medical College & SVPIMSR HOSPITAL
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CASE HISTORY SHEET: ENCEPHALITIS/ACUTE ENCEPHALITIS SYNDROME

PATIENT INFORMATION

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

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: .....Department..... 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 4weeks 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-compromised:** 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:**.....

CLINICALSYMPTOMS

[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 (4-10.5X10^3/mm^3)	..... 10^3/mm^3	**Eosinophil**	..... %	**SGOT**	..... U/L
Platelet Count (150-450X10^3/µl)	..... x10^3/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.***

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