Reporting of Case

# Case Investigation Form

Annexure- A

**To be filled at time of first contact with Health Facility by Medical Officer**

## ACUTE ENCEPHALITIC SYNDROME/ SUSPECTED JE CASE INVESTIGATION FORM

**EPID Number: AES-_____-_____-_____-_____** | **AESF-4**

### Reporting Information

| | |
|---|---|
| Date Case Reported: _____/_____/_____ | Notified by : _____ |
| Date Case Investigated: _____/_____/_____ | Investigated by: _____ |

### Patient Information

| | | | | |
|---|---|---|---|---|
| Patient's Name: _____ | | Sex: _____ | | |
| Date of Birth : _____/_____/_____ | | Age: years_____ months_____ | | |
| Father's Name:_____ | | Religion: Muslim / Hindu / Other | | |
| Address: | | Landmark: | | |
| Village / Mohalla: _____ | | Block / Urban Area: _____ _____ | | |
| District : _____ | | State: _____ | Setting: Urban/ Rural | |

### Travel History over past Two Weeks from Onset of First Symptoms

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dates of visit | Date from : | | | | | | |
| | Date to : | | | | | | |
| Address | | | | | | | |
| Block | | | | | | | |
| District and State | | | | | | | |

### Immunization History

| | |
|---|---|
| JE immunization: Yes / No / Partial / Unknown | Date of last JE immunization: _____/_____/_____ |

### Signs and Symptoms

| | | |
|---|---|---|
| Date of onset of first symptoms:_____/_____/_____ | Headache: Yes / No / Unknown | |
| Change in mental Status: Yes / No / Unknown | Paralysis: Yes / No / Unknown | |
| Fever: Yes / No / Unknown | Unconsciousness: Yes / No / Unknown | |
| Seizure: Yes / No / Unknown | Neck rigidity: Yes / No / Unknown | |

### Sample collection, tracking and results

| | Date Collection | Date Sent | Date Result | Condition* | Laboratory Result (Circle) |
|---|---|---|---|---|---|
| CSF | | | | | Positive Negative Not-tested Unknown |
| Serum 1 | | | | | Positive Negative Not-tested Unknown |
| Serum 2 | | | | | Positive Negative Not-tested Unknown |

### Diagnosis and final classification

| | | | | |
|---|---|---|---|---|
| Final Classification: | Laboratory confirmed JE / Probable JE / AES unknown / AES other agent | | | |
| Clinical Diagnosis: _____ | | | | |

### Discharge Status

| | | | | |
|---|---|---|---|---|
| Status at discharge: | Alive / Dead / Unknown | Date of discharge: _____/_____ _/_____ | | |
| If alive, status of recovery: | Recovered completely / Recovered with disability | | | |
| If died, date of death: _____/_____/_____ | | | | |
| *Condition is adequate if specimen is transported in reverse cold chain | | | | (Name & Signature) Designation |

Reporting of Case

# Laboratory Request Form

Annexure- B

To be filled at time of first contact with Health Facility by Medical Officer

## JAPANESE ENCEPHALITIS LABORATORY REQUEST AND REPORT FORM

**AESF-5**

| | | | | |
|---|---|---|---|---|
| | | | Patient Number: | Date: / / |
| Patient name: | | | | |
| Age: | | | | |
| Name of parent of guardian: | | | | |
| Province: | | | District: | |
| Town/Village: | | | Name of health facility: | |
| Number of doses of Japanese Encephalitis Vaccine: | | | | Date of last dose: / / |
| Date of onset of illness: | | | | |
| Name & address of treating doctors: | | | | |
| Clinical Features: | | | | |

| SPECIMENT TYPE | SPECIMEN ID | DATE OF COLLECTION | DATE OF SHIPMENT |
|---|---|---|---|
| (1) | | / / | / / |
| (2) | | / / | / / |
| (3) | | / / | / / |

| | | |
|---|---|---|
| Name of person to whom laboratory results should be sent: | | |
| Address: | | |
| | | |
| Telephone Number: | Fax Number: | E-mail: |

**For use by the receiving laboratory:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Name of laboratory: | | | | | | |
| Name of person receiving the specimen: | | | | | | |
| Specimen condition*: | | | | | | |
| SPECIMEN TYPE | DATE RECEIVED IN LAB | DATE RESULT | TEST TYPE | TEST RESULT | Date result to program/ sender | Remarks |
| | / / | / / | | | / / | |
| | / / | / / | | | / / | |
| | / / | / / | | | / / | |

*** Sample is good if:**

- There is no leakage
- Of adequate quantity
- Brought in cold chain
- Documentation is complete

**If sample is bad specify**

Add in the following information:

Fever at onset: Y ☐ N ☐ Duration:

Seizures: Y ☐ N ☐

Altered level of consciousness: Y ☐ N ☐

Neck rigidity: Y ☐ N ☐

**Any other information:** _____

Source : WHO Draft document operational guidelines

(Name & Signature)
Designation