AES Case Investigation Form

Hospital Registration No: _____ **AES No: _____**

1. Investigation Information: Name of Investigator(s): _____

Date Case Reported: _____ /_____ /_____ Designation: _____
Date Case Investigated: ____ / ____ / ____

2. Case Identification: Patient's Name: ____ _____

Date of Birth: ____ / ____ /___ __ Age: years ___ months ___ Sex: ___

Parents Name/: _____ Permanent address:
Contact No:_____ Village:_____
Gewog:_____
Residing Address _____ Dzongkhag:_____

3. **Hospitalization**: Yes/No Date of Hospitalization: _____ / _____ / _____

Name of Hospital:_____

Clinical Diagnosis:_____

Outcome: Recovered completely /Recovered with disability/ Death/Unknown

4. **Sign and Symptoms:**

Date of onset of symptoms: _____/_____/_____

Rapid Onset: Yes / No / Unknown Change in mental status: Yes / No / Unknown

Headache: Yes / No / Unknown Seizure: Yes / No / Unknown

Neck Stiffness: Yes / No / Unknown Stupor: Yes / No / Unknown

Paresis : Yes / No / Unknown

Travel History (2 weeks before the onset): Yes / No / Unknown

If yes, where: _____

5. Specimens Collection

Specimens type	Date of sample collected	Date of sample sent to Lab (RCDC)
Serum 1		
Serum 2		
CSF		

6. Case Classification: Lab confirmed / Probable /AES-other agent /AES-unknown

7 Signature of investigator:_____

Case Definition of AES: Clinically, a case of Acute Encephalitis Syndrome (AES) is defined as a person of any age, in any geographical region, at any time of year with the acute onset of fever and a change in mental status (including symptoms such as confusion, disorientation, coma, or inability to talk) AND/OR new onset of seizures (Excluding febrile seizures).

8. To be filled out by RCDC

Date of specimen received: ____/____/_____

Condition of sample */ circle it*

Serum 1 Good / poor

Serum 2 Good / Poor

CSF Good / Poor

Date test performed: _____/_____/_____

Test performed by: Name: _____Designation:_____

Type of test: _____

RCDC Laboratory results:

Serum 1 Positive / Negative / Equivocal / Pending

Serum 2 Positive / Negative / Equivocal / Pending

CSF Positive / Negative / Equivocal / Pending

Date Results sent to CEU: ____/_____/_____ other test if done and result_____

Specimens sent to reference lab: Yes / No

Date specimens sent to reference lab: ____/____/_____

Comments: _____

9. To be filled out by Reference Lab.

Name/location of laboratory: _____ Date test performed: ___/___/____

Test performed by: Name: _____ Designation: _____

Type of test: _____

Reference Laboratory results:

Serum 1 Positive / Negative / Equivocal / Pending

Serum 2 Positive / Negative / Equivocal / Pending

CSF Positive / Negative / Equivocal / Pending

Date Results sent to NHL / CEU/WHO: ____/_____/_____

Comments: _____