SHETH VADILAL SARABHAI GENERAL HOSPITAL
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DEPARTMENT OF MICROBIOLOGY

SPECIMEN REQUEST FORM **National Institute of Virology PUNE**

Japanese Encephalitis / Acute Encephalitis Syndrome

Name (First) _____	(Middle) _____	(Last) _____
Sex Male/ Female ☐	Date of birth __/__/____	Age ☐☐ Yrs ☐☐ Months
House address / Landmark _____	Locality _____ _____	District _____ State _____
Inpatient REG No	Hospital _____	Telephone No.
Date admitted __/__/____	Outcome - Discharged / Death/LAMA Date __/__/____	
Required ICU care Y/N ☐, Duration ____ days		Required ventilator Y/N ☐
Complications Y/N ☐ Specify		Sequelae Y/N ☐, _____
Underlying disease Y/N ☐	Details _____	
Vaccinations Y/N ☐	Details BCG/ Polio / DPT / Measles / JE _____	
Travel outside Y/N ☐	Details _____	
Additional comments _____		

SPECIMEN INFORMATION **For NIV STAFF ONLY** **Sp** (n) ☐

TYPE	DATE	TEST/S	LABEL	RECEIPT	NIV No.	Remarks
CSF						
Serum1						
Serum2						

CLINICAL INFORMATION **On Admission**

Fever Y/N ☐ ____ days	Highest Temp ___ deg C/F	Date of Onset __/__/___
Change in Mental status ☐ Confusion ☐ Disorientation ☐ Coma ☐ Inability to talk ☐ Neck rigidity ☐	Increased irritability ☐ Increased Somnolence ☐ Abnormal behavior ☐ Neurological deficit ☐ Paralysis ☐ Other _____	Date of Onset __/__/___ Duration ___ days ___hrs
Seizures Y/N ☐ Febrile seizures Y/N ☐	Date of onset __/___/____ Duration _____ min	New onset ☐Recovery within _____ min
Pallor / Anemia **Y/N**	Rash Y/N Type	Petachie Y/N
Oral Ulcers Y/N	Nodules on palm Y/N	Edema Y/N
Respiratory System	CVS	Chest
Hepatomegaly Y /N/ JP	Spleenomegaly Y /N /JP	Per Abdominal exam
Bladder	Bowel	Other
Plantar reflex ☐	Tone Power	DTR

CSF cell count _____ Pleocytosis (>5 cells) ☐	CT ☐ Abnormal ☐ MRI ☐ Abnormal ☐	EEG Y/N ☐ EEG s/o encephalitis ☐
Diagnosis _____ Differential diagnosis _____		Acute Encephalitis Syndrome (AES) ☐ Possible agent: _____
Signature (Name) _____		Telephone Date __/__/____