Tick-Borne Encephalitis Virus Subtype Infections in Latvia

Case Report Form

Subject ID: __ __ __ __

Informed Consent/Assent and Demography

Indicate which Informed Consent/Assent form(s) was/were signed prior to data collection:

	YES	NA	Date Signed (YYYY MM DAY)
Subject Informed Consent (14+ yrs)	☐	☐	
Parent Informed Consent (children <18 yrs)	☐	☐	

Or, indicate below if consent/assent was not obtained:

☐ **Subject Consent/Assent not obtained**

Sex: ☐ **Male** ☐ **Female** ☐ **Unknown** **Age _____**

Indicate subject's Region of Residence in Latvia and specify their Living Area within the region:

☐ **Riga, specify area:**
☐ **Vidzeme, specify area:**
☐ **Kurzeme, specify area:**
☐ **Latgale, specify area:**
☐ **Zemgale, specify area:**
☐ **Unknown**

Underlying Conditions/Prior Illnesses (check if any significant conditions/prior illnesses)	
☐ **Immunodeficiency, Specify:**	☐ **Cancer, Specify:**
☐ **Immunosuppressive medication, Specify:**	☐ **Other, specify:**

Vaccination history

Has the subject received any TBE vaccination(s)? ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

IF YES, please record all previous doses:

Dose #	Vaccine Name			Date (YYYY MM DAY)
	☐ FSME-IMMUN /TicoVac	☐ Encepur	☐ Other, specify:	
	☐ FSME-IMMUN /TicoVac	☐ Encepur	☐ Other, specify:	
	☐ FSME-IMMUN /TicoVac	☐ Encepur	☐ Other, specify:	

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	☐ FSME-IMMUN /TicoVac	☐ Encepur	☐ Other, specify:	
	☐ FSME-IMMUN /TicoVac	☐ Encepur	☐ Other, specify:	
	☐ FSME-IMMUN /TicoVac	☐ Encepur	☐ Other, specify:	

Was subject regularly vaccinated/were all doses given according to recommended schedule?
☐ **YES** ☐ **NO, please describe:**

TBE Epidemiological link		
Occupational Risk Factors (check if any occupational risk)		
☐ **Forest Worker**	☐ **State Environmental Inspector**	
☐ **State Environmental Inspector**	☐ **Hunter**	
☐ **Farmer**	☐ **National Armed Forces Personnel**	
☐ **Ministry of the Interior with special service ranks**	☐ **Other, specify_____**	
Leisure Activity Risk Factors (check if any leisure risk)		
☐ **Outdoor sports**	☐ **Camping**	
☐ **Berry/flower/mushroom picking**	☐ **Other, specify:**	
☐ **Walking/hiking**		
Tick Bite History		
☐ **YES, Date _____(YYYY/MM/DD)** **Multiple tick bite in last 30 days?** ☐ **YES** ☐ **No**	☐ **NO**	☐ **UNK**
Exposure to Infected Food Source		
☐ **YES, Date _____(YYYY/MM/DD)** **Describe infected food source:**	☐ **NO**	☐ **UNK**
TBE Infection History (Past)		
☐ **YES, Date _____(YYYY/MM/DD)** **If YES, Please fill "TBE Disease" Section in the End.**	☐ **NO**	☐ **UNK**

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Laboratory tests (TBEV subtype detection)

	POSITIVE	BORDERLINE	NEGATIVE	RESULT
Detection of TBEV (whole virus) IgG antibodies by standard ELISA (Euroimmun, Germany)	☐	☐	☐	
Detection of TBE-specific NS1 IgG antibodies in the serum by NS1 IgG ELISA	☐	☐	☐	
TBEV subtype detection: ☐ European, ☐ Siberian, ☐ Far-Eastern.				

TBE Disease

Clinical Symptoms (check if symptom is present)

TBE General Clinical Symptoms:
Date of onset, if known (YYYY/MM/DD):

- ☐ **Headache**
- ☐ **Fever, If present, biphasic?** ☐ **Yes** ☐ **No**
- ☐ **Myalgia**
- ☐ **Arthralgia**
- ☐ **Nausea/Vomiting**
- ☐ **General Fatigue**
- ☐ **Photophobia**
- ☐ **Phonophobia**
- ☐ **Dizziness**
- ☐ **Erythema, Location and Size:_____**

TBE Neurological Clinical Symptoms:
Date of onset, if known (YYYY/MM/DD):

- ☐ **Meningeal signs:** ☐**neck stiffness/nuchal rigidity** ☐**Kernig sign**
- ☐ **Cranial Nerve Palsy, specify nerve:_____**
  ☐ **bulbar dysfunction** ☐**facial palsy** ☐ **oculomotor disturbance**
- ☐ **Paresis:** ☐**central** ☐ **peripheral**
  Location and Grade:_____
- ☐ **Coordination Disturbances**
- ☐ **Radicular/Other Pain, Location:_____**
- ☐ **Altered consciousness**
- ☐ **Tremor**
- ☐ **Urine retention**
- ☐ **Cognitive disturbances**
- ☐ **Other_____**

Does subject have clinical symptoms of CNS inflammation? ☐ **YES**, specify below: ☐ **NO**

☐ **Meningitis** ☐ **Encephalitis** ☐ **Myelitis** ☐**Meningo-encephalitis** ☐ **Other, specify _____**

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TBE disease severity:

☐ **Mild** (predominantly meningeal symptoms, including fever, headache, rigidity of the neck, and nausea)

☐ **Moderate** (monofocal symptoms of the CNS and/ or moderate diffuse brain dysfunction)

☐ **Severe** (multifocal symptoms of the CNS and/or severe diffuse brain dysfunction).

	Laboratory Tests				
	YES	**BORDERLINE**	**NO**	**NOT ASSESSED**	**RESULT**
Detection of TBE-specific IgM antibodies in the serum (Standard ELISA)	☐	☐	☐	☐	
Detection of TBE-specific IgG antibodies in the serum (Standard ELISA)	☐	☐	☐	☐	
Lumbar Puncture					
Detection of IgM or IgM and IgG in CSF	☐	☐	☐	☐	
***CSF pleocytosis (>5 x 10^6 leukocytes/liter)*?**	☐	☐	☐	☐	
***Control Lumbar Puncture CSF pleocytosis (>5 x 10^6 leukocytes/liter)*?**	☐	☐	☐	☐	

Hospitalization Status

Date of Hospitalization (YYYY/MM/DD): _____ **Hospitalization in days _____**

Hospitalized in ICU: ☐ YES, days _____, ☐ NO

Therapy	
☐ **Use of intracranial hypertension reducing medications, If YES, please specify:**	☐ **Corticosteroids** ☐ **Diuretics** ☐ **Other _____**

Date of Discharge (YYYY/MM/DD): _____ ☐ **NA, Subject died**

Date of Death (YYYY/MM/DD):

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Early Functional and Neurological Deficits/Sequelae

☐ **Specify:**

☐ **Specify:**

☐ **Specify:**

☐ **Specify:**

☐ **Specify:**

☐ **Specify:**