

Free Living Ameba Case Report

Date of Report: _____

Demographics

Patient's Last Name		First	M.I.	Age	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic		Race: <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____			County and State of Residence: _____ County and State of Treatment: _____	
Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				Country of origin: _____		
Length of time since immigrated: _____				Occupation: _____		

Exposure History

County/State of Suspected Exposure: _____ / _____ Number of persons exposed (if known): _____

Source of possible exposure, if known: (please check all that apply and provide best estimates of dates)

Water Exposures	Type:	Date(s):	Type:	Date(s):	Type:	Date(s):		
<input type="checkbox"/> Yes	<input type="checkbox"/> Canal	_____	<input type="checkbox"/> Private Club Pool	_____	<input type="checkbox"/> Community Pool	_____		
<input type="checkbox"/> No	<input type="checkbox"/> Lake	_____	<input type="checkbox"/> Private Home Pool	_____	<input type="checkbox"/> Apartment Pool	_____		
<input type="checkbox"/> Unknown	<input type="checkbox"/> Pond	_____	<input type="checkbox"/> Fill-and-Drain Pool	_____	<input type="checkbox"/> Fountain	_____		
	<input type="checkbox"/> Ocean	_____	<input type="checkbox"/> Hotel Pool	_____	<input type="checkbox"/> Water park	_____		
	<input type="checkbox"/> River/Stream	_____	<input type="checkbox"/> Spring (hot/cold)	_____				
	<input type="checkbox"/> Well	_____	<input type="checkbox"/> Spa/hot tub/whirlpool	_____				
	<input type="checkbox"/> Other, specify _____	_____		Date(s): _____				
<i>If "yes", please fill out section on right</i>								
Water Activities		Yes	No	Unknown		Yes	No	Unknown
<input type="checkbox"/> Yes	Diving into water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snorkeling/scuba diving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No	Inhaled water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swimming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unknown	Jumped into water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water sports (skiing etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Swallowed water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wore nose clip or plugged nose when jumping/diving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Splashed water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify _____			
<i>If "yes", please fill out specifics on right</i>								
Soil Exposures	Type:	Date(s):				Occupational Exposures		
<input type="checkbox"/> Yes	<input type="checkbox"/> Gardening	_____				<input type="checkbox"/> Farmer/rancher		
<input type="checkbox"/> No	<input type="checkbox"/> Composting	_____				<input type="checkbox"/> Firefighter		
<input type="checkbox"/> Unknown	<input type="checkbox"/> Farm/Ranch	_____				<input type="checkbox"/> Lifeguard/pool attendant		
	<input type="checkbox"/> Other, specify: _____	_____	Date(s): _____			<input type="checkbox"/> Other, specify: _____		
<i>If "yes", please fill out specifics on right</i>								

Route of Entry if known: (please check all that apply) Inhalation Contact Other, specify: _____
 Ingestion Via Wound

If Water Source, Please List Source Characteristics:

Name of Water Exposure: _____ Geospatial Coordinates: _____ Thermally Polluted: Y / N

Size of Body Water: < 10 acres Water Turbidity: Clear Water level: Low High Flow Rate: Slow

10-100 acres >100 acres Cloudy Murky Unknown Normal Flood Stage Normal Fast

Unknown Unknown Unknown Unknown

Ambient Air Temperature: ___ F/C Water Temperature: ___ F/C Depth: _____

Travel History last 2 years: Yes No Unknown If yes, please specify in table below:

Locations	Dates (from – to)

Past Medical History:

Please check all conditions/symptoms that patient has currently or has had within past 2 years:

Treatment/drugs:

- Excessive antibiotic use (specify in Provider comments)
- Illegal drug use, specify: _____
- Immunosuppressants
- Radiation therapy
- Steroid use

HIV/AIDS:

HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
On Antiretrovirals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Other Immunocompromised Conditions

- Alcohol misuse Diabetes mellitus
- G6PD deficiency Liver cirrhosis
- Malnourishment Pregnancy (recent)
- Renal failure Lymphoproliferative disease
- Systemic Lupus Erythematosus (SLE)
- Cancer, specify: _____
- Other hematologic disease, specify: _____
- Other autoimmune disease, specify: _____
- Organ transplant, specify: _____

ENT/Respiratory:

- Otitis
- Rhinitis
- Broken Nose
- Deviated septum
- Tuberculosis
- Other lung disease, specify: _____

Other Conditions:

- Sinusitis
- Epistaxis
- Nasal Surgery
- Pharyngitis
- Pneumonitis
- Dermatitis
- Skin infections
- Eye infection
- Other, specify: _____
- Injury, specify: _____

Current Illness

Date of Illness onset: _____ Duration of illness: (in days) _____

Was patient admitted to hospital for current illness? Yes No Unknown

If Yes, Date of **most recent** hospitalization: _____ Duration of most recent hospitalization (in days): _____

Hospital Name: _____ City: _____ State: _____

Physician Name 1: _____ E-mail (if avail): _____ Phone: _____

Physician Name 2: _____ E-mail (if avail): _____ Phone: _____

Other Recent Hospitalizations: Yes No Unknown

Dates (from- to)	Diagnosis

History of Present Illness:

Please provide a brief description of the patient's clinical course, prior to hospitalization:

Signs/Symptoms on Presentation (most recent hospitalization):

Vital Signs:

Temperature: _____ F / C P: _____ bpm R= _____ breaths/min BP: _____ mmHg

General:

- | | | | |
|---|-----------------------|--|-----------------------|
| <input type="checkbox"/> Fever | Duration (days) _____ | <input type="checkbox"/> Myalgia | Duration (days) _____ |
| <input type="checkbox"/> Nausea | _____ | <input type="checkbox"/> Back Pain | _____ |
| <input type="checkbox"/> Vomiting | _____ | <input type="checkbox"/> Cough | _____ |
| <input type="checkbox"/> Diarrhea | _____ | <input type="checkbox"/> Shortness of breath | _____ |
| <input type="checkbox"/> Weight loss | _____ | <input type="checkbox"/> Sinus problems | _____ |
| <input type="checkbox"/> Anorexia | _____ | <input type="checkbox"/> Abnormal reflexes | _____ |
| <input type="checkbox"/> Headache | _____ | <input type="checkbox"/> Disorientation | _____ |
| <input type="checkbox"/> Stiff neck | _____ | <input type="checkbox"/> Lethargy/fatigue | _____ |
| <input type="checkbox"/> Other general symptom/sign, specify: _____ | | _____ | |

Visual

- | | |
|---|-----------------------|
| <input type="checkbox"/> Blurred vision | Duration (days) _____ |
| <input type="checkbox"/> Diplopia | _____ |
| <input type="checkbox"/> Photophobia | _____ |
| <input type="checkbox"/> Other visual changes, specify: | _____ |

Neurologic:

- | | | | | | |
|--|-----------------------|---|-----------------------|---|-----------------------|
| <input type="checkbox"/> Altered mental status | Duration (days) _____ | <input type="checkbox"/> Dysphagia | Duration (days) _____ | <input type="checkbox"/> Weakness | Duration (days) _____ |
| <input type="checkbox"/> Aphasia | _____ | <input type="checkbox"/> Facial numbness | _____ | <input type="checkbox"/> Hemiparesis | _____ |
| <input type="checkbox"/> Ataxia | _____ | <input type="checkbox"/> Hallucinations | _____ | <input type="checkbox"/> Altered sense of taste | _____ |
| <input type="checkbox"/> Behavioral changes | _____ | <input type="checkbox"/> Combativeness | _____ | <input type="checkbox"/> Altered sense of smell | _____ |
| <input type="checkbox"/> Coma | _____ | <input type="checkbox"/> Hyperreflexia | _____ | <input type="checkbox"/> Decerebrate posturing | _____ |
| <input type="checkbox"/> Confusion | _____ | <input type="checkbox"/> Loss of balance | _____ | <input type="checkbox"/> Decorticate posturing | _____ |
| <input type="checkbox"/> Cranial nerve VI deficit | _____ | <input type="checkbox"/> Numbness | _____ | <input type="checkbox"/> Fixed, dilated pupils | _____ |
| <input type="checkbox"/> Cranial nerve VII deficit | _____ | <input type="checkbox"/> Seizures | _____ | <input type="checkbox"/> Nystagmus | _____ |
| <input type="checkbox"/> Cranial nerve XII deficit | _____ | <input type="checkbox"/> Upgoing toes | _____ | | |
| <input type="checkbox"/> Other cranial nerve deficit, specify: _____ Duration: _____ | | <input type="checkbox"/> Other neurologic deficit, specify: _____ Duration: _____ | | | |

Skin Lesions: Yes No Unknown *If yes, please specify in table below.*

Lesion type	Anatomic location	Size	Number	Duration (days)
Ulcers				
Plaques				
Erythematous nodules				
Other				

Other Symptoms/Signs:

Other, specify: _____

Signs/Symptoms developed while in hospital:

General:

- | | |
|---|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Myalgia |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Abnormal Reflexes |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Lethargy/fatigue |
| <input type="checkbox"/> Other general symptom/sign, specify: _____ | |

Visual :

- | |
|---|
| <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Diplopia |
| <input type="checkbox"/> Photophobia |
| <input type="checkbox"/> Other visual changes, specify: _____ |

Neurologic:

- | | | |
|--|---|---|
| <input type="checkbox"/> Altered mental status | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Altered sense of taste |
| <input type="checkbox"/> Aphasia | <input type="checkbox"/> Facial numbness | <input type="checkbox"/> Altered sense of smell |
| <input type="checkbox"/> Ataxia | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Decerebrate posturing |
| <input type="checkbox"/> Behavioral changes | <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Decorticate posturing |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Hyperreflexia | <input type="checkbox"/> Fixed, dilated pupils |
| <input type="checkbox"/> Combativeness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Nystagmus |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Cranial nerve VI deficit | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cranial nerve VII deficit | <input type="checkbox"/> Upgoing toes | |
| <input type="checkbox"/> Cranial nerve XII deficit | <input type="checkbox"/> Weakness | |
| <input type="checkbox"/> Other Cranial nerve deficit, specify: _____ | <input type="checkbox"/> Other neurologic deficit, specify: _____ | |

Skin Lesions: Yes No *If yes, please specify in table below:*

Lesion type	Anatomic location	Size	Number
Ulcers			
Plaques			
Erythematous nodules			
Other			

Other Symptoms/Signs:

Other, specify: _____

Diagnostic Tests: Note please provide dates when possible. If date not available, provide hospital day (i.e. CSF tap on Hosp. Day 2)

LABORATORY TESTING

CSF	Date _____	Date _____	Date _____
	Results	Results	Results
Opening pressure (mmH2O)			
WBC count (per mm ³)			
RBC count (per mm ³)			
Neutrophil %			
Monocyte %			
Lymphocyte %			
Bands %			
Eosinophil %			
Protein (mg/100ml)			
Glucose (mg/100ml)			
CSF Culture: *			
CSF PCR: *			
CSF latex agglutination: *			
CSF mount: <i>Please indicate preparation type and findings, if any</i>	<input type="checkbox"/> Centrifuged <input type="checkbox"/> Stained <input type="checkbox"/> Wet Amebae present? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/> Centrifuged <input type="checkbox"/> Stained <input type="checkbox"/> Wet Amebae present? Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/> Centrifuged <input type="checkbox"/> Stained <input type="checkbox"/> Wet Amebae present? Y <input type="checkbox"/> N <input type="checkbox"/>

* Please provide results for all bacteria, viral and/or parasitic testing.

Presenting Lab Values: Date: _____

	Results
RBC count (per mm ³)	
Hematocrit %	
WBC count (per mm ³)	
Neutrophil %	
Lymphocyte %	
Monocyte %	
Eosinophil %	
Bands %	
CD4 count (per mm ³)	
Protein (mg/100ml)	
Sodium (mEq/L)	
Potassium (mEq/L)	
Chloride (mEq/L)	
Bicarbonate (mEq/L)	
BUN (mg/100ml)	
Creatinine (mg/100ml)	
Glucose (mg/100ml)	

Serology:

Date	Result

Cultures for Free Living Amebae:

Source	Date	Result	
<input type="checkbox"/> Blood		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Skin		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Brain		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Abscess		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Other, specify: _____		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba

PCR for Free Living Amebae:

Source	Date	Result	
<input type="checkbox"/> Blood		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Skin		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Brain		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Abscess		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba
<input type="checkbox"/> Other, specify: _____		<input type="checkbox"/> Negative	<input type="checkbox"/> + Balamuthia
		<input type="checkbox"/> + Naegleria	<input type="checkbox"/> + Acanthamoeba

HISTOPATHOLOGY

Brain biopsy: Yes No Unknown

	Date:	Date:
Location		
Timing	<input type="checkbox"/> Antemortem <input type="checkbox"/> Postmortem <input type="checkbox"/> Unknown	<input type="checkbox"/> Antemortem <input type="checkbox"/> Postmortem <input type="checkbox"/> Unknown
Results (check all that apply)	<input type="checkbox"/> Amebic trophozoites	<input type="checkbox"/> Amebic trophozoites
	<input type="checkbox"/> Amebic cysts	<input type="checkbox"/> Amebic cysts
	<input type="checkbox"/> Ameba, not specified	<input type="checkbox"/> Ameba, not specified
	<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Necrosis
	<input type="checkbox"/> Encephalomalacia	<input type="checkbox"/> Edema
	<input type="checkbox"/> Abscess	<input type="checkbox"/> Vasculitis
	<input type="checkbox"/> Perivascular Inflammation	<input type="checkbox"/> Perivascular Inflammation
	<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Thrombosis
	<input type="checkbox"/> Neovascularization	<input type="checkbox"/> Neovascularization
	<input type="checkbox"/> Neutrophilic inflammation / infiltrate	<input type="checkbox"/> Neutrophilic inflammation / infiltrate
	<input type="checkbox"/> Lymphocytic inflammation / infiltrate	<input type="checkbox"/> Lymphocytic inflammation / infiltrate
	<input type="checkbox"/> Granulomatous inflammation	<input type="checkbox"/> Granulomatous inflammation
	<input type="checkbox"/> Granuloma	<input type="checkbox"/> Granuloma
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Encephalitis	
<input type="checkbox"/> Meningoencephalitis	<input type="checkbox"/> Meningoencephalitis	
Other Results/ Comments		

Skin biopsy: Yes No Unknown

	Date:	Date:
Location		
Timing	<input type="checkbox"/> Antemortem <input type="checkbox"/> Postmortem <input type="checkbox"/> Unknown	<input type="checkbox"/> Antemortem <input type="checkbox"/> Postmortem <input type="checkbox"/> Unknown
Results	<input type="checkbox"/> No amebae seen	<input type="checkbox"/> No amebae seen
	<input type="checkbox"/> Amebic trophozoites	<input type="checkbox"/> Amebic trophozoites
	<input type="checkbox"/> Amebic cysts	<input type="checkbox"/> Amebic cysts
	<input type="checkbox"/> Amebae, not specified	<input type="checkbox"/> Amebae, not specified
Other Results/ Comments		

Sinus biopsy: Yes No Unknown

	Date:	Date:
Location		
Timing	<input type="checkbox"/> Antemortem <input type="checkbox"/> Postmortem <input type="checkbox"/> Unknown	<input type="checkbox"/> Antemortem <input type="checkbox"/> Postmortem <input type="checkbox"/> Unknown
Results	<input type="checkbox"/> No amebae seen	<input type="checkbox"/> No amebae seen
	<input type="checkbox"/> Amebic trophozoites	<input type="checkbox"/> Amebic trophozoites
	<input type="checkbox"/> Amebic cysts	<input type="checkbox"/> Amebic cysts
	<input type="checkbox"/> Amebae, not specified	<input type="checkbox"/> Amebae, not specified
Other Results/ Comments		

Other biopsy results:

DIAGNOSTIC IMAGING

CT: Date of First CT: _____

Lesion location: (please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Basal Ganglia | <input type="checkbox"/> Left Occipital | <input type="checkbox"/> Left Temporal |
| <input type="checkbox"/> Brainstem | <input type="checkbox"/> Right Occipital | <input type="checkbox"/> Right Temporal |
| <input type="checkbox"/> Right Cerebellum | <input type="checkbox"/> Left Parietal | <input type="checkbox"/> Thalamus |
| <input type="checkbox"/> Left Cerebellum | <input type="checkbox"/> Right Parietal | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Left Frontal | <input type="checkbox"/> Pons | |
| <input type="checkbox"/> Right Frontal | <input type="checkbox"/> Spinal Cord | |

Lesion: (please check all that apply)

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Abscess | <input type="checkbox"/> Hyperdense | <input type="checkbox"/> Enhancing |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Hypodense | <input type="checkbox"/> Ring enhancing |
| <input type="checkbox"/> Erosion | <input type="checkbox"/> Infarcts | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Mass | <input type="checkbox"/> Ventriculomegaly |
| <input type="checkbox"/> Herniation | <input type="checkbox"/> Multifocal lesions | <input type="checkbox"/> Other, specify: _____ |

Additional Description, if needed: _____

Please list dates of subsequent CT scans and changes noted:

Date	Findings

MRI: Date of First MRI: _____

Lesion location: (please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Basal Ganglia | <input type="checkbox"/> Left Occipital | <input type="checkbox"/> Left Temporal |
| <input type="checkbox"/> Brainstem | <input type="checkbox"/> Right Occipital | <input type="checkbox"/> Right Temporal |
| <input type="checkbox"/> Right Cerebellum | <input type="checkbox"/> Left Parietal | <input type="checkbox"/> Thalamus |
| <input type="checkbox"/> Left Cerebellum | <input type="checkbox"/> Right Parietal | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Left Frontal | <input type="checkbox"/> Pons | |
| <input type="checkbox"/> Right Frontal | <input type="checkbox"/> Spinal Cord | |

Lesion: (please check all that apply)

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Abscess | <input type="checkbox"/> Hyperdense | <input type="checkbox"/> Enhancing |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Hypodense | <input type="checkbox"/> Ring enhancing |
| <input type="checkbox"/> Erosion | <input type="checkbox"/> Infarcts | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Mass | <input type="checkbox"/> Ventriculomegaly |
| <input type="checkbox"/> Herniation | <input type="checkbox"/> Multifocal lesions | <input type="checkbox"/> Other, specify: _____ |

Additional Description, if needed: _____

Please list dates of subsequent MRI scans and changes noted:

Date	Findings

Diagnosis:

Admitting diagnosis: _____ Date of Diagnosis: _____

- Encephalitis Meningoencephalitis
 Meningitis Other, Specify _____

Final diagnosis: _____ Date of Diagnosis: _____

- GAE (Acanthamoeba spp.) GAE (Balamuthia mandillaris) PAM (Naegleria fowleri)
 Disseminated Acanthamoebiasis Disseminated Balamuthiasis Other, specify: _____
 Acanthamoeba rhinosinusitis Balamuthia rhinosinusitis
 Cutaneous acanthamoebiasis Cutaneous balamuthiasis

Diagnosis Method:

Indirect Immunofluorescence (IIF)	<input type="checkbox"/>	Antemortem	<input type="checkbox"/>	Postmortem	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
PCR	<input type="checkbox"/>	Antemortem	<input type="checkbox"/>	Postmortem	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Histopathology	<input type="checkbox"/>	Antemortem	<input type="checkbox"/>	Postmortem	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
CSF Wet Mount	<input type="checkbox"/>	Antemortem	<input type="checkbox"/>	Postmortem	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Culture	<input type="checkbox"/>	Antemortem	<input type="checkbox"/>	Postmortem	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Other, Specify:		Antemortem	<input type="checkbox"/>	Postmortem	<input type="checkbox"/>	Unknown	<input type="checkbox"/>

Treatment:

Surgical resection: Yes No

Medications: (please check all that apply)

	Start date:	Stop date:	Dose Range	Route of Administration
<input type="checkbox"/> Acyclovir				
<input type="checkbox"/> Albendazole				
<input type="checkbox"/> Amphotericin B				
<input type="checkbox"/> Amphotericin B lipid				
<input type="checkbox"/> Amphotericin B liposomal				
<input type="checkbox"/> Azithromycin				
<input type="checkbox"/> Ceftriaxone				
<input type="checkbox"/> Ciprofloxacin				
<input type="checkbox"/> Chloramphenicol				
<input type="checkbox"/> Clarithromycin				
<input type="checkbox"/> Ethambutol				
<input type="checkbox"/> Fluconazole				
<input type="checkbox"/> Flucytosine				
<input type="checkbox"/> Isoniazid				
<input type="checkbox"/> Itraconazole				
<input type="checkbox"/> Ketoconazole				
<input type="checkbox"/> Mannitol				
<input type="checkbox"/> Metronidazole				
<input type="checkbox"/> Miconazole				
<input type="checkbox"/> Ornidazole				
<input type="checkbox"/> Pentamidine				
<input type="checkbox"/> Pyrimethamine				
<input type="checkbox"/> Rifampin				
<input type="checkbox"/> Steroid, specify _____				
<input type="checkbox"/> Streptomycin				
<input type="checkbox"/> Sulfonamide, specify _____				
<input type="checkbox"/> Sulfadiazine				
<input type="checkbox"/> Topical Chlorhexidine				
<input type="checkbox"/> Trimethoprim/sulfa				
<input type="checkbox"/> Voriconazole				
<input type="checkbox"/> Other, specify _____				
<input type="checkbox"/> Other, specify _____				
<input type="checkbox"/> Other, specify _____				

Other therapies: (please check all that apply)

	Start date:	Stop date:
<input type="checkbox"/> IV fluids		
<input type="checkbox"/> Total Parenteral Nutrition (TPN)		
<input type="checkbox"/> Dialysis for renal failure		
<input type="checkbox"/> Other, specify _____		
<input type="checkbox"/> Other, specify _____		
<input type="checkbox"/> Other, specify _____		

Outcome:

Survived? Yes No Unknown

If survived: Residual neurologic deficits? Yes No Unknown

If Yes, Please describe neurologic deficits: _____

Date of discharge: _____ OR Date of death: _____

If died: Cause of death:

- Brain death Removed life support
 Cardiorespiratory failure Other, specify: _____
 Herniation

Please provide a brief description of the patient's clinical course, complications, and any additional comments:

CDC USE ONLY:

1 st DASH #	
2 nd DASH #	
3 rd DASH #	
4 th DASH #	
5 th DASH #	
List additional DASH #s:	

Case report citation 1	
Case report citation 2	
List additional case citations	

Calculated durations:

Incubation period (days): _____
 Illness Onset to Admission (days): _____
 Illness Onset to Death (days): _____
 Exposure to Death (days): _____
 Clinical Stage at presentation: _____