Viral Encephalitis Testing

UR Medicine Labs—Central Laboratory

UR Medicine Labs performs nucleic acid amplification testing on CSF in-house (order **Meningitis Encephalitis PCR Panel**).

- Turn-around-time: 8 hours.
- CSF minimum requirement: 1.0 mL.

Aerobic culture and Gram stain are reflexed when the panel is ordered.

MENCP (UR Medicine Labs) Meningitis Encephalitis PCR Panel
Bacteria
Escherichia coli K1
Haemophilus influenza
Listeria monocytogenes
Neisseria meningitides
Streptococcus agalactiae (GBS)
Streptococcus pneumoniae
Viruses
Cytomegalovirus (CMV)
Enterovirus
Herpes simplex virus 1 (HSV-1)
Herpes simplex virus 2 (HSV-2)
Human herpes virus 6 (HHV-6)
Parechovirus
Varicella-zoster virus (VZV)
Fungi
*Cryptococcus neoformans/gatti**
The **Meningitis Encephalitis PCR Panel may not be optimal for the diagnosis of cryptococcal meningitis. Cryptococcus antigen (includes fungal culture) should be ordered if there is clinical suspicion for cryptococcal infection.*

NYS Department of Health—Wadsworth Center

The New York State Department of Health performs arbovirus testing on CSF (order **Viral Encephalitis PCR Panel**) and serum (order **Encephalitis Antibody Panel**).

- Turn-around-time: 7—14 days.
- CSF minimum requirement: 1.0 mL.
- Collect serum separator tube or red top for serum testing.

IMPORTANT! Also complete the attached Infection Diseases Requisition and fax it to 585-272-0165 (UR Medicine Labs—Virology) immediately.

ENCP (NYS Department of Health) Viral Encephalitis PCR Panel
CSF nucleic acid amplification tests
Adenovirus
Cytomegalovirus (CMV)
Enterovirus
Epstein-Barr virus (EBV)
Herpes simplex virus 1 (HSV-1)
Herpes simplex virus 2 (HSV-2)
Human herpes virus 6 (HHV-6)
Varicella-zoster virus (VZV)
Heartland virus*
Eastern equine encephalitis virus*
St. Louis encephalitis virus*
Powassan virus*
West Nile virus*
CSF antibodies by ELISA
West Nile virus IgM antibodies
**Tests for mosquito-borne viruses are performed in June—November only*

ENCAB (NYS Department of Health) Encephalitis Antibody Panel
Serum antibodies by ELISA
West Nile virus IgM antibodies
Serum antibodies by MIA
West Nile virus polyvalent antibodies
Powassan virus polyvalent antibodies
Serum IgG antibodies by IFA
Eastern equine encephalitis virus
Western equine encephalitis virus
California serogroup viruses
St. Louis encephalitis virus
Serum nucleic acid amplification tests
West Nile virus
Powassan virus
Heartland virus

Important information for completing the Infection Diseases Requisition

Testing will not be performed if the Infection Diseases Requisition is not received. Testing will be canceled if the requisition is not received within 7 days.

Complete the required information (*/**) in the *Patient Demographics and Requesting Provider*, *Specimen Information*, *Laboratory Examination Requested*, and *Clinical History* sections.

IMPORTANT! Provide the 'Date of Symptom(s) Onset' in the *Specimen information* section.

Check off the 'Serology' and/or 'Viral Encephalitis PCR Panel on CSF' checkboxes.

- *Viral Encephalitis PCR Panel*—Testing is performed only for CSF from hospitalized patients with a current diagnosis of 'viral encephalitis' (defined as temperature 100.4°F, altered mental status, and abnormal CSF). CSF submitted on patients no longer hospitalized or with a current diagnosis of 'viral meningitis' will be tested only for West Nile virus IgM antibody by ELISA.

NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Infection Diseases Requisition

Please send specimen(s) to: New York State Department of Health, Wadsworth Center
Address: David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208
Rabies Lab only: Courier Address: 5668 State Farm Road, Slingerlands, NY 12159

For more information about the Infectious Diseases laboratories at the Wadsworth Center, go to: https://www.wadsworth.org/programs/id

Patient Demographics and Requesting Provider

*required information

Last name or Patient code* | First name* | MI | DOB* | Sex*

___ | ___ | ___/___/____ | ☐ Male ☐ Female ☐ None Assigned

Permanent Street Address | Facility of Residence (if applicable) | City | State* | Zip Code

NYS County of Residence* | Patient Telephone Number ( ) – | Patient Reference Number | NYS DOH Outbreak Number | CDESS Case Number

Race (select one or more) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Current gender identity ☐ Male (M) ☐ Female (F) ☐ Transgender M-to-F ☐ Transgender F-to-M ☐ Nonconforming ☐ Other(specify)_____

Employer | Work Street Address | City | State | Zip Code

Occupation | Work Telephone Number ( ) –

Name- Health Care Provider (HCP) | National Provider Identifier (NPI):

HCP Telephone Number ( ) – | Zip Code for HCP

Submitting Facility (Laboratory report will be sent to this address)

*required information

Name* URMC Central Laboratory | Laboratory PFI 8305

Address* 211 Bailey Road West Henrietta, NY 14586 | NPI

Attention to / Contact Person Kelly DeLary, Supervisor | Telephone Number* (585) 275 – 1410

Specimen Information

*required information

Collection Date*: ___ / ___ / _____ Time Collected (if applicable): _____ Date of Symptom(s) Onset: ___ / ___ / ____

Source(s)* _____ Primary ___ Isolate ___ Autopsy ___

Specimen submitted on/in (specify media/preservative/cell line) _____ Submitter'sSpecimen Identifier(s) : _____

Laboratory Examination Requested

☐ Confirmation ☐ Identification / Detection Submitter Lab Findings: Smear/Stain/Other: _____

☐ Bacterial _____
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility
- ☐ Other susceptibility (please specify): _____

☐ Fungal _____
- ☐ Antimicrobial Resistance Laboratory Network Susceptibility
- ☐ Other Antifungal Susceptibility _____

☐ Mycobacterial _____

☐ Parasitic _____
- ☐ Malaria Drug Susceptibility

☐ Serology _____

☐ Viral** _____
- ☐ Viral Encephalitis PCR Panel on CSF
- ☐ Influenza Antiviral Susceptibility

☐ Other _____

Clinical History

COVID-19 First Test* ☐ Yes ☐ No ☐ Unknown ☐ Donor Screening Pregnant (trimester) ___

Relevant Exposure: ☐ Health Care Worker ☐ Resident in a congregate care setting ☐ Contact w/Known case ☐ Travel ☐ Animal ☐ Arthropod ☐ Food/Water

Exposure Detail: Hospitalized: ☐ Yes ☐ No ☐ ICU Hospital Name

Diagnosis: Fever (max): CSF: Glu Prot RBC WBC .

Relevant Treatment: Date: / / Relevant Immunization: Date: / / .

**Symptoms – select severity: ☐ Asymptomatic ☐ Mild ☐ Severe ☐ Unknown .

(Check all applicable below) Other symptoms: .

Cardiovascular	Central Nervous System	Rash	Respiratory	Miscellaneous	
☐ Endocarditis	☐ Altered Mental Status	☐ Hemorrhagic	☐ Bronchitis	☐ Arthralgia	☐ Lymphadenopathy
☐ Myocarditis	☐ Encephalitis	☐ Maculopapular	☐ Cough	☐ Conjunctivitis	☐ Malaise
☐ Pericarditis	☐ Headache	☐ Petechial	☐ Pneumonia	☐ Hepatitis	☐ Myalgia
	☐ Meningitis	☐ Vesicular	☐ Upper Respiratory	☐ Hepatomegaly	☐ Splenomegaly
	☐ Paralysis			☐ Immunocompromised	