



## 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 re-flexed 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.

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 Native Hawaiian or Pacific Islander		Asian White	Black or African American		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*	Laboratory PFI	
Address*	NPI	
Attention to / Contact Person	Telephone Number* ( ) -	

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's Specimen Identifier(s) :	

Laboratory Examination Requested	
Confirmation	Identification / Detection
Submitter Lab Findings: Smear/Stain/Other: _____	
<b>Bacterial</b>	<b>Parasitic</b>
Antimicrobial Resistance Laboratory Network Susceptibility	Malaria Drug Susceptibility
Other susceptibility (please specify): _____	<b>Serology</b>
<b>Fungal</b>	<b>Viral**</b>
Antimicrobial Resistance Laboratory Network Susceptibility	Viral Encephalitis PCR Panel on CSF
Other Antifungal Susceptibility _____	Influenza Antiviral Susceptibility
<b>Mycobacterial</b>	<b>Other</b>

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	