Viral Encephalitis Testing available at UR Medicine Labs

The New York State Department of Health Wadsworth Laboratory offers Viral Encephalitis testing on CSF and SERUM.

- Testing on CSF is ordered under ENCP (Encephalitis PCR Panel).
- Testing on SERUM is ordered under ENCAB (Encephalitis Antibody Panel).

Testing on CSF includes real-time PCR assays for:

Adenovirus DNA
Cytomegalovirus DNA
Enterovirus RNA
Epstein-Barr virus DNA
Herpes simplex virus 1 DNA
Herpes simplex virus 2 DNA
Human herpes virus 6 DNA
Varicella-zoster virus DNA

Heartland virus RNA (RT-PCR)*
Eastern equine encephalitis virus RNA (RT-PCR)*
Saint Louis encephalitis virus RNA (RT-PCR)*
West Nile virus RNA (RT-PCR)*
Powassan virus RNA (RT-PCR)*
*Tests for mosquito-borne diseases are not performed during the winter months

Note: West Nile IgM antibody by ELISA on CSF is also included

Testing on SERUM samples includes the following tests:

WNV IgM antibodies by ELISA
WNV and Powassan polyvalent antibodies by MIA
Arboviral IgG antibodies by IFA (Eastern Equine Encephalitis, Western Equine Encephalitis, California serogroup, St. Louis Encephalitis)
WNV, Powassan virus, and Heartland virus by PCR

Typical turnaround time (TAT) is 7 – 14 days (average 10). Testing is performed only for CSF specimens collected 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 antibody by ELISA. Specimen volume required is 1.0 ml.

IMPORTANT - The New York State Department of Health requires the attached *Infection Diseases Requisition* to be completed and submitted for viral encephalitis testing to be performed. Symptom onset date is required. Failure to complete and submit this form will result in a delay in testing.

Please complete the IDR form and fax to 585-475-0862 as soon as possible. If the form is not received by the Virology Lab within one week of the test request, the test will be canceled.

NOTE - If less than 1.0 ml CSF is submitted on patients with encephalitis, the quantity will not be sufficient to perform both West Nile Virus (WNV) ELISA and PCR panel testing.

For more timely results, the in-house Meningitis/Encephalitis PCR Panel (MENCP) tests for the following targets with an 8 hour TAT (CSF specimen volume required is 1.0 ml):

Cytomegalovirus
Enterovirus
Herpes simplex virus 1 and 2
Human herpes virus 6
Parechovirus
Varicella zoster virus

Escherichia coli
Haemophilus influenza
Listeria monocytogenes
Neisseria meningitidis
Streptococcus agalactiae
Streptococcus pneumoniae
Cryptococcus neoformans/gatti

Updated: 9/10/2021

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* ________ 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'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	

NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Non-Human Samples

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 Rd, Slingerlands, NY 12159

Submitter (test ordered by)

*required information

Name*:

Address*:

Contact Person*: Phone*: ( ) –

Sample Information

Collection Date*: / / Rabies Lab Only Second Collection Date: / /

NYSDOH Outbreak Number:

Collection Site:

Street Address:

City: State: Zip Code: NYS County:

Laboratory Examination Requested

☐ Bacterial ☐ Fungal ☐ Mycobacterial ☐ Parasitic ☐ Serology ☐ Viral ☐ Other

Suspect Organism/Agent:

Animal

☐ Domestic ☐ Wild

☐ Avian ☐ Mammal ☐ Reptile ☐ Other

Common Name or Species:

Submitter Sample Number: Sample Source:

Domestic Animal Owner Name: Animal Name:

Comments:

Food

Brand Name:

Lot Number: USDA Number: Sell By Date: / /

Sample Description:

Comments:

Environmental

Source Description:

Describe below samples taken; use separate sheets if necessary.

Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)	Sample type (sponge, swab, water, soil, etc.)	Identifier (Room number, etc.)

Comments: