



BioFire® FilmArray®

Meningitis/Encephalitis Panel

Thank you for sharing your case with BioFire! Please fill out to the best of your ability. At the end of the form, provide your electronic signature, and the submit button will populate an email for submission to marketingassistants@biofiredx.com.

Patient demographics

Geographical location (List state only) _____

Male Female Urban Community

Age _____

Relevant medical history

Co-morbidities (Please list)

Current illness (Chief complaints and observations)

Duration of symptoms: _____

Physical exam (Include abnormal findings, vital signs, if known)

Heart rate _____ Blood pressure _____

Temperature _____ spO2 _____

Respiratory rate _____ Neuro-imaging _____

Abnormal findings _____ Other _____

Other imaging Yes No _____

Legend:

- Y=yes
- N=no
- UNK=unknown
- P=positive
- N=negative

BioFire ME Panel results

- | | | |
|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> <i>Escherichia coli</i> K1 | <input type="checkbox"/> <i>Streptococcus pneumoniae</i> | <input type="checkbox"/> Human herpesvirus 6 (HHV-6) |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> | <input type="checkbox"/> Cytomegalovirus (CMV) | <input type="checkbox"/> Human parechovirus (HPeV) |
| <input type="checkbox"/> <i>Listeria monocytogenes</i> | <input type="checkbox"/> Enterovirus (EV) | <input type="checkbox"/> Varicella zoster virus (VZV) |
| <input type="checkbox"/> <i>Neisseria meningitidis</i> | <input type="checkbox"/> Herpes simplex virus 1 (HSV-1) | <input type="checkbox"/> <i>Cryptococcus neoformans/gattii</i> |
| <input type="checkbox"/> <i>Streptococcus agalactiae</i> | <input type="checkbox"/> Herpes simplex virus 2 (HSV-2) | |

Other diagnostics ordered and results

Gram stain results: _____

Culture results: _____

Protein: _____ Glucose: _____

WBC: _____

Other testing conducted for pathogen identification: _____

Impression (Including 1–3 differential diagnoses)

1. _____
2. _____
3. _____

Treatment

Empiric antimicrobial regimen: _____

Steroid therapy initiated? Yes No When? _____

Was antimicrobial therapy initiated prior to lumbar puncture (LP)? Yes No

Empiric antiviral regimen _____

Where was LP performed? _____ Opening pressure _____

Initiation/alteration of initial therapy based on Gram stain (If applicable): _____

Initiation/alteration of initial therapy based on BioFire ME Panel result (If applicable): _____

Initiation/alteration of initial therapy based on culture (If applicable): _____

Initiation/alteration of initial therapy based on other tests (If applicable): _____

Infection control

Was patient placed in isolation before BioFire ME Panel result? Yes No Duration _____

Was patient placed in isolation after BioFire ME Panel result? Yes No Duration _____

Was patient removed from isolation based on BioFire ME Panel result? Yes No Duration _____

Comment or rationale for infection control:

Outcomes

Discharged from ED Duration _____

Held in ED Duration _____

Transfer Where (Example: long-term chronic care facility, other hospital) _____

Admitted Unit _____ If ICU, days in ICU _____

Length of hospitalization _____

Please give a description of the patient's progression or clinical courses given.

Did the results of the BioFire ME Panel help impact patient management? If so, please explain.

Facility description (Check all that apply that best describes your facility)

Tertiary care hospital Teaching hospital University hospital

Community hospital Urgent care center Emergency center

Clinic Physician office Other _____

Adults/pediatrics Adults only Pediatrics only

Facility size (Number of beds) _____

Location (List state only) _____

Legal authorization to provide non-PHI data (Data use: check all that are permitted)

Case report for BioFire internal training purposes only

Case report for BioFire customer-facing materials

Please list any other restrictions: _____

Can we use geographical region of facility: Yes No

If yes, please select from the following US regions:

Northeast Mid-Atlantic Southeast

Midwest Gulf States Southwest

Pacific Northwest Other (Specify) _____

Would you be interested in presenting your case as a poster with a short presentation? Yes No

Where? _____

Would you be interested in publishing your case? Yes No

What journal? _____

By providing this information, I and my institution agree that the information contained in this Case Report Form may be used by BioFire Diagnostics, LLC (BioFire) for marketing purposes, subject to the following limitations (if any):

Please omit the following information from any marketing use by BioFire:

Physician specialty

Type of hospital/facility (Size, teaching hospital, etc.)

Year of case

Location (List state only)

I also represent and warrant that I have the authority to permit BioFire to use the information contained herein. I understand that all identifying patient information will be removed prior to submission of this form to BioFire.

Name: _____ Signature: _____