FOR LOCAL USE ONLY

Name of person completing form: _____ State assigned patient ID: _____

Affiliation_____ Phone: _____Email: _____

Name of physician who can provide additional clinical/lab information, if needed _____

Affiliation_____ Phone: _____ Email: _____

Name of main hospital that provided patient's care: _____ State: _____ County: _____

----------***DETACH and transmit only lower portion to limbweakness@cdc.gov if sending to CDC***----------

Acute Flaccid Myelitis: Patient Summary Form

Form Approved
OMB No. 0920-0009
Exp Date: 04/30/2016

Form to be completed by, or in conjunction with, a physician who provided care to the patient during the neurological illness. Once completed, submit to Health Department (HD). HD can also facilitate specimen testing.

1. Today's date__ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **2**. State assigned patient ID: _____

3. Sex: ☐ M ☐F **4.** Date of birth __ __/ __ __/ __ __ __ __ Residence: **5**. State_____ **6.** County_____

7. Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White *(check all that apply)* **8**. Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

9. Date of onset of limb weakness __ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **10**. Was patient admitted to a hospital? ☐yes ☐no ☐unknown

11. Date of admission to **first** hospital__ __/__ __/__ __ __ __ **12.**Date of discharge from **last** hospital__ __/__ __/__ __ __ __(or ☐ still hospitalized at time of form submission)

13. Did the patient die from this illness? ☐yes ☐no ☐unknown **14**. If yes, date of death__ __/__ __/__ __ __

SIGNS/SYMPTOMS/CONDITION:				
	Right Arm	Left Arm	Right Leg	Left Leg
15. Since neurologic illness onset, which limbs have been acutely weak? [*indicate yes(y), no (n), unknown (u)* ***for each limb***]	Y N U	Y N U	Y N U	Y N U
16. Date of neurologic exam (recorded at most severe weakness to point of completing this form) *(mm/dd/yyyy)*	__ __/__ __/__ __ __ __			
17. At the time of most severe weakness, reflexes in the **most affected** limb(s):	☐ Areflexic/hyporeflexic (0-1) ☐ Normal (2) ☐ Hyperreflexic (3-4+)			
At ANY time during the illness, was there:				
18. Any sensory loss/numbness in the **affected** limb(s), at any time during the illness? (paresthesias should not be considered here)	Y N U			
19. Any pain or burning in the **affected** limb(s)?	Y N U			

	Yes	No	Unk/Not Recorded (NR)
20. Sensory level on the torso (i.e., reduced sensation below a certain level of the torso)?			
21. Did patient have any of the cranial nerve features below? (If yes, check all that apply):			
☐Diplopia/double vision (If yes, circle the cranial nerve involved if known: 3 / 4 / 6)			
☐Loss of sensation in face ☐ Facial droop ☐Hearing loss ☐ Dysphagia ☐ Dysarthria			
22. Bowel or bladder incontinence?			
23. Change in mental status (e.g., confused, disoriented, encephalopathic)?			
24. Seizure(s)?			
25. Receipt of positive pressure ventilation, including invasive or non-invasive ventilation and including BiPAP or CPAP?			

Other patient information:

In the 4-weeks **BEFORE onset** of **limb weakness**, did patient:	Yes	No	Unk/NR	
26. Have a respiratory illness?				**27**. If yes, onset date __ __/__ __/__ __ __ __
28. Have a gastrointestinal illness (e.g., diarrhea or vomiting)?				29. If yes, onset date __ __/__ __/ __ __ __ __
30. Have a new onset rash?				31. If yes, onset date __ __/__ __/__ __ __ __
32. Have a fever, measured by parent or provider and ≥ 38.0°C/100.4°F?				**33**. If yes, onset date __ __/__ __/__ __ __ __

34. Receive any immunosuppressing agent(s) (BEFORE WEAKNESS ONSET)?				Form Approved OMB No. 0920-0009 Exp Date: 04/30/2016 **35.** If yes: Date of first administration: __ __/ __ __ / __ __ __ __ Name of medication: _____ Mode of administration: ☐IM ☐IV ☐Oral Dosage / duration / overall amount administered: _____
36. Travel outside the US?				**37.** If yes, list country:
38. At onset of limb weakness, does patient have any underlying illnesses?				**39.** If yes, list:
40. On the day of onset of limb weakness, did patient have a fever?				(see definition for fever above in 32.)

Polio vaccination history:	
41. How many doses of **inactivated polio vaccine (IPV**) are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
42. How many doses of **oral polio vaccine (OPV)** are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
43. If you do not have documentation of the *type* of polio vaccine received what is total number of **documented** polio vaccine doses received before onset of weakness?	_____doses ☐unknown

Neuroradiographic findings:

MRI of spinal cord **44.** Was MRI of spinal cord performed? ☐ yes ☐no ☐ unknown

45. If yes, how many documented spinal MRIs were performed? _____

*If yes to Q44, complete Q46-Q71 based on **most abnormal spine MRI*** **46.** Date of most abnormal spine MRI __ __/__ __/__ __ __ __

47. Levels imaged: ☐cervical ☐thoracic ☐lumbosacral ☐unknown

48. Location of lesions:	☐cervical cord ☐thoracic cord ☐conus ☐cauda equina ☐unknown	Levels of cord affected (if applicable): **49**. Cervical: _____ **50.** Thoracic: _____
For **cervical and thoracic cord** lesions	**51.** What areas of spinal cord were affected?	☐predominantly gray matter ☐predominantly white matter ☐both equally affected ☐ unknown
	52. Was there cord edema?	☐ yes ☐no ☐ unknown
53. Gadolinium (GAD) used: ☐yes ☐no ☐ unknown		***(If NO, skip to question 59)***
For **cervical, thoracic cord or conus** lesions	**54**. Did any **gray** matter lesions enhance with GAD?	☐ yes ☐ no ☐ unknown
	55. Did any **white** matter lesions enhance with GAD?	☐ yes ☐ no ☐ unknown
	56. Did any cervical / thoracic nerve roots enhance with GAD?	☐ yes ☐ no ☐ unknown
For **cauda equina** lesions	**57**. Did the **ventra**l nerve roots enhance with GAD?	☐ yes ☐ no ☐ unknown

	58. Did the **dorsal** nerve roots enhance with GAD?	☐ yes ☐ no ☐ unknown

MRI of brain

59. Was brain/brainstem/cerebellum MRI performed? ☐ yes ☐no ☐ unknown (*If NO, skip to Q72*) **60.** Date of study __ __/__ __/__ __ __ __

61. Any **supratentorial** (i.e, lobe, cortical, subcortical, basal ganglia, or thalamic) lesions	☐ yes ☐ no ☐ unknown	
	62.If yes, indicate location(s)	☐cortex ☐basal ganglia ☐thalamus ☐ subcortex ☐unknown ☐Other (specify): _____
63. Any **brainstem** lesions?	☐ yes ☐ no ☐ unknown	
	64. If yes, indicate location:	☐midbrain ☐pons ☐medulla ☐unknown
65. Any **cranial nerve** lesions?	☐ yes ☐ no ☐ unknown	
	66. If yes, indicate which CN(s):	CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
		CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
67. Any lesions affecting the **cerebellum**?	☐ yes ☐ no ☐ unknown	
68. Gadolinium (GAD) used: ☐ yes ☐ no ☐ unknown	***(If NO, skip to question 72)***	
69. Did any supratentorial lesions enhance with GAD?	☐ yes ☐ no ☐ unknown	
70. Did any brainstem lesions enhance with GAD?	☐ yes ☐ no ☐ unknown	
71. Did any cranial nerve lesions enhance with GAD?	☐ yes ☐ no ☐ unknown	

72. Was an EMG done? ☐ yes ☐ no ☐ unknown If yes, date __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*

73. If yes, was there evidence of acute motor neuropathy, motor neuronopathy, motor nerve or anterior horn cell involvement? ☐ yes ☐ no ☐ unk

CSF examination: **74**. Was a lumbar puncture performed? ☐ yes ☐ no ☐ unknown

If yes, complete 74 (a,b) (*If more than 2 CSF examinations, list the first 2 performed)*

	Date of lumbar puncture	WBC/mm3	% neutrophils	% lymphocytes	% monocytes	% eosinophils	RBC/mm3	Glucose mg/dl	Protein mg/dl
74a. CSF from LP1									
74b. CSF from LP2									

Pathogen testing performed:

75. **Was CSF tested?** ☐ yes ☐ no ☐ unknown **Specimen Collection Date __ __ / __ __/ __ __ __ __**

If 'yes', was specimen tested for the following:

	Test Type	**Test Result**	**Typed (if positive)?**	**Type**
Enterovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
West Nile Virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
West Nile Virus ☐ yes ☐ no ☐ unknown	IgM	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Unknown		
Herpes simplex virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Cytomegalovirus ☐ yes ☐no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Varicella zoster virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Was other pathogen identified: ☐ yes ☐ no ☐ unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

76. Was a RESPIRATORY TRACT specimen tested? ☐ yes ☐ no ☐ unknown **Specimen Collection Date** __ __ / __ __/ __ __ __ __
Type of specimen: ☐ nasopharyngeal swab ☐ nasal wash/aspirate ☐ oropharyngeal swab ☐ other, specify: _____
If 'yes', was specimen tested for the following:

	Test Type	Test Result	Typed (if positive)?	Type
Enterovirus/rhinovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Adenovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Influenza virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Was other pathogen identified: ☐ yes ☐ no unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

77. Was a STOOL specimen tested? ☐ yes ☐ no ☐ unknown **Specimen Collection Date** __ __ / __ __/ __ __ __ __
If 'yes', was specimen tested for the following:

	Test Type	Test Result	Typed (if positive)?	Type
Non-polio Enterovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Poliovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Poliovirus ☐ yes ☐ no ☐ unknown	Culture	☐ Positive ☐ Negative ☐ Pending		
Was other pathogen identified: ☐ yes ☐ no unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

78. Was SERUM tested? ☐ yes ☐ no ☐ unknown **Specimen Collection Date** __ __ / __ __/ __ __ __ __
If 'yes', was specimen tested for the following:

	Test Type	Test Result	Typed (if positive)?	Type
West Nile Virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
West Nile Virus ☐ yes ☐ no ☐ unknown	IgM	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Unknown		
Was other pathogen identified: ☐ yes ☐ no unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

79. Was/Is a **specific etiology** considered to be the most likely cause for the patient's neurological illness? ☐ yes ☐ no ☐ unknown
80. **If yes**, please list etiology and reason(s) considered most likely cause _____
_____

81. If patient is a confirmed or probable case, will specimens be sent to CDC for testing? ☐ yes ☐ no ☐ unknown
82. If yes, types of specimens that will be sent to CDC for testing:
☐ CSF ☐ Nasal wash/aspirate ☐BAL spec ☐Tracheal aspirate ☐NP/OP swab ☐Stool ☐Serum ☐ Other, list _____

Acute Flaccid Myelitis case definition

(http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/2015PS/2015PSFinal/15-ID-01.pdf)

Criteria

An illness with onset of acute focal limb weakness AND

- a magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments, OR
- cerebrospinal fluid (CSF) with pleocytosis (white blood cell count >5 cells/mm^3)

Case Classification

Confirmed:

- An illness with onset of acute focal limb weakness AND
- MRI showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments

Probable:

- An illness with onset of acute focal limb weakness AND
- CSF showing pleocytosis (white blood cell count >5 cells/mm^3).