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| This form should only be completed for individuals meeting the El Escorial Criteria for diagnosing ALS including definite, probable, and possible ALS. The diagnosis of ALS requires the presence of each of the following:   1. Lower Motor Neuron signs (by clinical, electrophysiological, or neuropathological examination) in 1 or more of 4 regions (bulbar, cervical, thoracic, and lumbosacral). Signs of lower motor neuron degeneration include:  weakness, muscle atrophy and fasciculations. 2. Upper Motor Neuron signs (by clinical examination) in 1 or more of the 4 regions.  Signs of upper motor neuron degeneration included:  slowed movements, increased muscle tone or spasticity, spastic gait. 3. Progression of signs within a region or to other regions |
| Definite ALS = Upper Motor Neuron + Lower Motor Neuron signs in 3 regions  Probable ALS = Upper Motor Neuron + Lower Motor Neuron signs in 2 regions with Upper Motor Neuron signs rostral to Lower Motor Neuron signs  Probable ALS, lab supported = Upper Motor Neuron + Lower Motor neuron signs in 1 region with evidence by EMG of lower motor neuron involvement in another region.  Possible ALS = Upper Motor Neuron + Lower Motor Neuron signs in 1 region or Upper Motor Neuron signs in 2 or 3 regions, such as monomelic ALS, progressive bulbar palsy, and primary lateral sclerosis |

**Demographic Information**

1. Subject Name:

Last Name

First Name

Middle Name or Initial

Suffix

1. Address:

Number

Street

City

State

Zip Code

1. Social Security Number (last 5 digits only)

\_\_ - \_\_ \_\_ \_\_ \_\_

1. Date of Birth: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

(mm/dd/yyyy)

1. Sex:  Male  Female

1. Race (as reported by subject – check all that apply):

* Asian
* Black/African American
* White
* Unknown
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Ethnicity:

* Hispanic or Latino
* Non Hispanic or Latino
* Unknown

1. Country of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis Information**

1. El Escorial Criteria as determined by an ALS specialist (check one)

* Definite
* Probable
* Probable (lab supported)
* Possible
* Not Classifiable

1. Date of Diagnosis \_\_ \_\_/\_\_ \_\_ \_\_ \_\_

(mm/yyyy)

1. Date of Onset of Symptoms \_\_ \_\_/\_\_ \_\_ \_\_ \_\_

(mm/yyyy)

1. Provider Making the Report

* Neurologist (ALS specialist)
* Neurologist (other)
* Physiatrist
* Family/Internal Medicine/General Practice

1. Does the patient have dementia diagnosed by a neurologist?

* Yes  No  Don’t know

1. Does the patient have an immediate family member (parent, sibling, child) who has/had ALS?

 Yes  No  Don’t know

15. Payer Type

* Medicare  self-pay
* Medicaid  Veterans Administration
* HMO  Other
* Private Insurance