Date Completed __ __/_ __/__ __
Name of person completing the form _____
Job Title _____
Name of Practice _____
Phone number (__ __ __) __ __ __ - __ __ __ __

Form Approved
OMB No. 0923-XXXX
Exp. Date xx/xx/20xx

ALS Case Reporting Form

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 _____
2. Address:
   Number _____
   Street _____
   City _____
   State _____
   Zip Code _____
3. Social Security Number (last 5 digits only)
   __ - __ __ __ __
4. Date of Birth: __ __/__ __/__ __ __ __
   (mm/dd/yyyy)
5. Sex: ☐ Male ☐ Female
6. Race (as reported by subject – check all that apply):
   ☐ Asian
   ☐ Black/African American
   ☐ White
   ☐ Unknown
   ☐ Other:_____
7. Ethnicity:
   ☐ Hispanic or Latino
   ☐ Non Hispanic or Latino
   ☐ Unknown
8. Country of Birth:_____

Diagnosis Information

9. El Escorial Criteria as determined by an ALS specialist (check one)
   ☐ Definite
   ☐ Probable
   ☐ Probable (lab supported)
   ☐ Possible
   ☐ Not Classifiable
10. Date of Diagnosis __ __/__ __ __ __
    (mm/yyyy)
11. Date of Onset of Symptoms __ __/__ __ __ __
    (mm/yyyy)
12. Provider Making the Report
    ☐ Neurologist (ALS specialist)
    ☐ Neurologist (other)
    ☐ Physiatrist
    ☐ Family/Internal Medicine/General Practice
13. Does the patient have dementia diagnosed by a neurologist?
    ☐ Yes ☐ No ☐ Don't know
14. 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

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