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
    - ☐ Medicaid
    - ☐ HMO
    - ☐ Private Insurance
    - ☐ self-pay
    - ☐ Veterans Administration
    - ☐ Other

Public reporting burden of this collection of information is estimated to average 5 minutes including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the data collection of information. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, GA 30333; ATTN: PRA (0923-XXXX).

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