**Acute Neurological Illness with Limb Weakness in Children: Patient Summary 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.*

ID \_\_\_ \_\_\_--\_\_\_ \_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Confirmation of case :** | Yes | No | Unknown |
| a. Neurological findings (upon examination by clinician) include focal limb weakness |  |  |  |
| b. MRI of spinal cord demonstrates spinal lesion largely restricted to the gray matter |  |  |  |
| c. Age at onset of limb weakness is 21 years or less |  |  |  |
| d. Onset of limb weakness was August 1, 2014 or later |  |  |  |

**Answer to ALL 4 criteria must be YES. (If not, do not complete this form)**

**1**.Today’s Date\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ (mm/dd/yyyy)  **2**.Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**.Affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.**Name of physician who can provide additional clinical/lab information, if needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5**.Affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6.**Name of main hospital that provided patient’s care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **7**.State: \_\_\_\_\_  **8**.County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9.**Patientl ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State ID \_\_\_ \_\_\_--- \_\_\_ \_\_\_ *(HD to assign using State abbrev, then number: aa--##, use leading zero)*

**10**.Patient sex: 🞎 M 🞎F Age: \_\_\_\_\_\_years and \_\_\_\_\_\_\_months  **11**.Patient’s residence: State\_\_\_\_\_\_\_\_County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12**.Race: 🞎Asian 🞎Black or African American 🞎Native Hawaiian or Other Pacific Islander 🞎American Indian or Alaska Native

🞎White (check all that apply) **13**. Ethnicity: 🞎Hispanic 🞎Non-Hispanic

**14.** Date of onset of limb weakness: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ (mm/dd/yyyy) **15.**Date of admission to first hospital\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

**16.** Date of discharge from last hospital\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ (🞎 still hospitalized)

**17**. Current clinical status: 🞎recovered 🞎 not recovered, but improved 🞎not improved 🞎Deceased: date of death\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

**Signs/symptoms/condition at ANY time during the illness:**

|  |  |  |  |
| --- | --- | --- | --- |
| **18**.Number of limbs with acute weakness \_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Grade of motor weakness, of most affected muscle group: ǂ | | | |
| **19**. At peak severity 🞎 0/5 🞎1/5 🞎 2/5 🞎3/5 🞎4/5 🞎 5/5 **20**. Date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | | | |
| **21**. At most recent examination 🞎 0/5 🞎1/5 🞎 2/5 🞎3/5 🞎4/5 🞎 5/5 **22.** Date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | | | |
|  | Yes | No | Unknown |
| **23** .Clinical involvement of ≥1 cranial nerve(s)? |  |  |  |
| **24**. Sensory level or numbness present? (do not include pain) |  |  |  |
| **25**. Bowel or bladder incontinence? |  |  |  |
| **26** .Cardiovascular instability? |  |  |  |
| **27.** Change in mental status? |  |  |  |
| **28**. Seizure(s)? |  |  |  |
| **29.** Received care in ICU because of neurological condition? |  |  |  |
| **30**. Received ventilatory support because of neurological condition? |  |  |  |

ǂ 0/5: no contraction; 1/5: muscle flicker, but no movement; 2/5: movement possible, but not against gravity; 3/5: movement possible against gravity, but not against resistance by examiner; 4/5: movement possible against some resistance by examiner; 5/5: normal strength

|  |  |
| --- | --- |
| **Polio vaccination history:** | |
| a. How many doses of inactivated polio vaccine **(IPV)** have been documented to have been received by the patient before the onset of weakness? | \_\_\_\_\_\_\_doses 🞎unknown |
| a. How many doses of oral polio vaccine **(OPV)** have been documented to have been received by the patient before the onset of weakness? | \_\_\_\_\_\_\_doses 🞎unknown |
| c. If you do not have documentation of **type** of polio vaccine received:  What is total number of documented polio vaccine doses? | \_\_\_\_\_\_\_doses 🞎unknown |
| Were any of these doses administered outside the US? | 🞎yes 🞎no 🞎unknown |

**Neuroradiographic findings**: indicate based on most abnormal study

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**MRI of spinal cord** **42**. Date of study \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ (mm/dd/yyyy)

**43**.Levels imaged: 🞎cervical 🞎thoracic 🞎lumbosacral 🞎unknown

**44**. Gadolinium used? 🞎yes 🞎no 🞎unknown

|  |  |  |
| --- | --- | --- |
| **45.**Location of lesions: | 🞎cervical cord 🞎thoracic cord 🞎conus 🞎cauda equina 🞎unknown | Levels affected (if applicable):  **46**. Cervical: \_\_\_\_\_\_\_\_\_  **47**. Thoracic: \_\_\_\_\_\_\_\_\_ |
| For **cervical and thoracic** cord lesions | **48.**What areas of spinal cord  affected? | 🞎gray matter 🞎white matter 🞎both 🞎unknown |
|  | **49**.Was there cord edema? | 🞎yes 🞎no 🞎unknown |
|  | **50**. Site of lesion(s) | 🞎mostly right side 🞎mostly left side 🞎both sides 🞎unknown |
| For **cervical, thoracic cord or conus** lesions | **51**.Did any lesions enhance with  GAD? | 🞎yes 🞎no 🞎unknown |
| For **cauda equina** lesions | **52**. Did the **ventra**l nerve roots  enhance with GAD? | 🞎yes 🞎no 🞎unknown |
|  | **53**. Did the **dorsal** nerve roots  enhance with GAD? | 🞎yes 🞎no 🞎unknown |

**MRI of brain** **54.** Date of study \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ (mm/dd/yyyy)

**55**. Gadolinium used? 🞎 yes 🞎no 🞎unknown

|  |  |  |
| --- | --- | --- |
| **56**. Any **supratentorial** (i.e, cortical, subcortical, basal ganglia, or thalamic) lesions | 🞎yes 🞎no 🞎unknown | |
| **57.** Any **brainstem** lesions? | 🞎yes 🞎no 🞎unknown | |
|  | **58**. If yes, indicate location | 🞎midbrain 🞎ventral pons 🞎dorsal pons 🞎medulla 🞎unknown |
|  | **59**.If yes, did any lesions  enhance with GAD | 🞎yes 🞎no 🞎unknown |
| 58. Any lesions affecting the **deep nuclei** (e.g, dentate) of the **cerebellum**? | 🞎yes 🞎no 🞎unknown |  |
| **59.** Any **cranial nerve** lesions? | 🞎yes 🞎no 🞎unknown |  |
|  | **60**. If yes, indicate which CN and side: | CN\_\_\_\_\_ 🞎R 🞎L 🞎 both R and L |
|  |  | CN\_\_\_\_\_ 🞎R 🞎L 🞎 both R and L |
|  |  | CN\_\_\_\_\_ 🞎R 🞎L 🞎 both R and L |
|  | **61**. If yes, did any lesions  enhance with GAD | 🞎yes 🞎no 🞎unknown |

**CSF examination** (if more than two examinations, list earliest and then most abnormal)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Date of lumbar puncture | WBC/mm3 | % neutrophils | % lymphocytes | % monocytes | % eosinophils | RBC/mm3 | Glucose mg/dl | Protein mg/dl |
| **62.** CSF from LP1 |  |  |  |  |  |  |  |  |  |
| **63.** CSF from LP2 |  |  |  |  |  |  |  |  |  |

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**Pathogen testing performed**

|  |  |
| --- | --- |
| **64**. Was **CSF** tested for **enterovirus/rhinovirus?** | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: |
|  | Interpretation: |
|  |  |
|  | If test result was positive, was typing performed?  🞎yes 🞎no 🞎unknown |
|  | If yes, method and result: |
|  |  |
|  |  |
|  |  |
| **65**. Was **CSF** tested for **West Nile** virus? | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: Interpretation: |
|  |  |
| **66**. Was **CSF** tested for **St. Louis encephalitis virus**? | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: Interpretation: |
|  |  |
| **67**. Was **CSF** tested for **La Crosse virus**? | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: Interpretation: |
|  |  |
| **68**. If **CSF** testing identified **any pathogen,** describe: | Date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: Interpretation: |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **69**. Was **a respiratory tract specimen** tested for **enterovirus/rhinovirus?** | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of specimen: |
|  | Type of testing: |
|  | Result: |
|  | Interpretation: |
|  |  |
|  | If test result was positive, was typing performed?  🞎yes 🞎no 🞎unknown |
|  | If yes, method and result: |
|  |  |

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|  |  |
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| **70.** Was **a stool specimen** tested for **enterovirus/rhinovirus?** | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of specimen: 🞎rectal swab 🞎 whole stool 🞎unknown |
|  | Type of testing: |
|  | Result: |
|  | Interpretation: |
|  |  |
|  | If test result was positive, was typing performed?  🞎yes 🞎no 🞎unknown |
|  | If yes, method and result: |
|  |  |

|  |  |
| --- | --- |
| **71.** Was **serum** tested for:  **West Nile virus?** | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: Interpretation: |
|  |  |
| **72. St. Louis encephalitis virus?** | 🞎yes 🞎no 🞎 unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: Interpretation: |
|  |  |
| **73. La Crosse virus?** | 🞎yes 🞎no 🞎unknown If yes, date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  | Type of testing: |
|  | Result: Interpretation: |

**74.** Describe any other laboratory finding(s) considered to be significant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**75.** Was/Is a **specific etiology** considered to be the most likely cause for the patient’s neurological illness? 🞎yes 🞎no **76.** If yes, please list etiology and reason considered most likely cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**77.** Other information you would like us to know \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**78.** Indicate which type(s) of specimens from the patient are currently stored, and could be available for possible additional testing at CDC:

🞎 CSF 🞎 Nasal wash/aspirate 🞎BAL spec 🞎tracheal aspirate 🞎NP/OP swab 🞎Stool 🞎Serum 🞎 No specimens stored

🞎 Other, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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