OMB Approved
OMB No. 0920-0009
Expiration Date: 04/2016

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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.

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

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Neuroradiographic findings: indicate based on most abnormal study

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

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		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:

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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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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____

____

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 ____

____

77. Other information you would like us to know ____

____

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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