CDC ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*Form to be completed by, or in conjunction with, a physician who provided care to the patient during the neurological illness.*

|  |  |  |  |
| --- | --- | --- | --- |
| **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(s) largely restricted to or predominantly affecting the gray matter.  (Terms in the spinal cord MRI report such as “affecting mostly gray matter,” “affecting the anterior horn or anterior horn cells,” “affecting the central cord,” “anterior myelitis,” or “poliomyelitis” would all be consistent with this. If still unsure if this criterion is met, consider asking the radiologist directly.) |  |  |  |
| 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 yes, continue to Part II on pages 2 - 5.***

Page 1 of 6

***If you have any questions about whether your patient meets all 4 criteria, please e-mail us at limbweakness@cdc.gov***

CDC ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*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.*

**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.** Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**10**. State ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **11**. Patient’s sex: 🞎 M 🞎F **12**. Patient’s age: \_\_\_\_\_\_years AND \_\_\_\_\_\_\_months Patient’s residence: **13**. State\_\_\_\_\_\_\_ **14.** County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

🞎White *(check all that apply)* **16**. Ethnicity: 🞎Hispanic 🞎Non-Hispanic

**17.** Date of onset of limb weakness: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ *(mm/dd/yyyy)* **18**. Was patient admitted to a hospital? 🞎yes 🞎no 🞎unknown **19.**Date of admission to **first** hospital\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ **20.**Date of discharge from **last** hospital\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_(or 🞎 still hospitalized)

**21**. At the time of last / most recent follow-up, how would you best characterize the patient’s outcome, in terms of affected limb strength: 🞎 Completely recovered; back to baseline strength with no residual sequelae 🞎 Partially recovered; some improvement in limb strength, but with ongoing weakness compared to initial presentation 🞎 No demonstrable improvement in limb strength; essentially as weak as at time of first presentation 🞎 Decline in limb strength; weaker in affected limbs than at time of first presentation 🞎 Unknown / unable to comment 🞎 Deceased: **22**.Date of death\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_

23. At the time of last / most recent follow-up, how would you best characterize the patient’s functional outcome, in terms of effect of limb weakness on activities of daily living? **(Not applicable if Q21 is ‘Deceased’)**

🞎 Completely functionally recovered; able to do all activities as prior to acute illness 🞎 Somewhat functionally impaired; able to do some activities on own, but needs caregiver assistance with other things (dressing, tying shoes, feeding, etc.) 🞎 Completely dependent on caregiver for basic daily functions

Page 2 of 6

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Signs/symptoms/condition at ANY time during the illness:** | | | | | | | |
|  | Right Arm | Left Arm | Right Leg | | | Left Leg | |
| **24**. Since neurologic illness onset, which limbs have been acutely weak? [*indicate yes(y), no (n), unknown (u)* ***for each limb***] | Y N U | Y N U | Y N U | | | Y N U | |
| **25.** Date of neurologic exam (recorded at worst weakness thus far) *(mm/dd/yyyy)* | \_\_ \_\_ /\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | | | | | | |
| **26**. Reflexes in the **affected** limb(s): (recorded at worst weakness thus far) | 🞎 Areflexic/hyporeflexic (0-1) 🞎 Normal (2) 🞎 Hyperreflexic (3-4+) | | | | | | |
| **27**. Any sensory loss/numbness in the **affected** limb(s), at any time during the illness? (paresthesias should not be considered here) | Y N U | | | | | | |
| **28**. Any pain or burning in the **affected** limb(s)? (at any time during illness) | Y N U | Y N U | Y N U | | | Y N U | |
|  | | | | Yes | No | | Unknown |
| **29**. Sensory level on the torso (ie, reduced sensation below a certain level of the torso)? (at any time during illness) | | | |  |  | |  |
| **30.** At any time during the illness, please check if the patient had any of the following cranial nerve signs: | | | |  | | | |
| 🞎Diplopia/double vision (If yes, circle the cranial nerve involved if known: 3 / 4 / 6 ) | | | |
| 🞎Loss of sensation in face 🞎 Facial droop 🞎Hearing loss 🞎 Dysphagia 🞎 Dysarthria | | | |
| **31**. Any pain or burning in neck or back? (at any time during illness) | | | |  |  | |  |
| **32**. Bowel or bladder incontinence? (at any time during illness) | | | |  |  | |  |
| **33** .Cardiovascular instability (e.g, labile blood pressure, alternating tachy/bradycardia)? (at any time during illness) | | | |  |  | |  |
| **34.** Change in mental status (e.g, confused, disoriented, encephalopathic)? (at any time during illness) | | | |  |  | |  |
| **35**. Seizure(s)? (at any time during illness) | | | |  |  | |  |
| **36.** Received care in ICU because of neurological condition? (at any time during illness) | | | |  |  | |  |
| **37**. Received invasive ventilatory support (e.g, intubation, tracheostomy) because of neurological condition? | | | |  |  | |  |

CDC ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other patient information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Within the 4-week period **BEFORE onset** of **limb weakness**, did patient: | Yes | No | Unk |  |
| **38**. Have a respiratory illness? |  |  |  | **39**. If yes, date of onset \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| **40**. Have a fever, measured by parent  or provider and ≥ 38.0°C/100.4°F? |  |  |  | **41**. If yes, date of onset \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| **42.** Receive oral, IM or IV steroids? |  |  |  |  |
| **43.** Receive any other systemic  Immunosuppressant(s)? |  |  |  | **44.** If yes, list: |
| **45.** Travel outside the US? |  |  |  | **46.** If yes, list country |
|  |  |  |  |  |
| **47**. Does patient have any underlying illnesses? |  |  |  | **48.** If yes, list |
| **49.** On the **day of onset of limb weakness**, did patient have a fever? (see definition above) |  |  |  |  |

|  |  |
| --- | --- |
| **Polio vaccination history:** | |
| **50**. How many doses of **inactivated polio vaccine (IPV**) are **documented** to have been received by  the patient before the onset of weakness? | \_\_\_\_\_\_\_doses 🞎unknown |
| **51.** How many doses of **oral polio vaccine (OPV)** are **documented** to have been received by the  patient before the onset of weakness? | \_\_\_\_\_\_\_doses 🞎unknown |
| **52.** If you do not have documentation of the *type* of polio vaccine received:  **a**.What is total number of **documented** polio vaccine doses received before onset of weakness? | \_\_\_\_\_\_\_doses 🞎unknown |

**Neuroradiographic findings**: (*Indicate based on most abnormal study)*

**MRI of spinal cord** **53**. Date of study \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ *(mm/dd/yyyy)*

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

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

|  |  |  |
| --- | --- | --- |
| **56.** Location of lesions: | 🞎cervical cord 🞎thoracic cord 🞎conus 🞎cauda equina 🞎unknown | Levels of cord affected (if applicable):  **57**. Cervical: \_\_\_\_\_\_\_\_\_ **58.** Thoracic: \_\_\_\_\_\_\_\_\_ |
| For **cervical and thoracic** **cord** lesions | **59.** What areas of spinal cord  were affected? | 🞎predominantly gray matter 🞎predominantly white matter 🞎both equally affected 🞎unknown |
|  | **60**. Was there cord edema? | 🞎yes 🞎no 🞎unknown |
|  |  |  |
| For **cervical, thoracic cord or conus** lesions | **61**. Did any lesions enhance with  GAD? | 🞎yes 🞎no 🞎unknown |
|  |  |  |
| For **cauda equina** lesions | **62**. Did the **ventra**l nerve roots  enhance with GAD? | 🞎yes 🞎no 🞎unknown |
|  | **63**. Did the **dorsal** nerve roots  enhance with GAD? | 🞎yes 🞎no 🞎unknown |

Page 3 of 6

CDC ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MRI of brain** **64.** Date of study \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ *(mm/dd/yyyy)*

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

|  |  |  |
| --- | --- | --- |
| **66**. Any **supratentorial** (i.e, lobe, cortical, subcortical, basal ganglia, or thalamic) lesions | 🞎yes 🞎no 🞎unknown |  |
|  | **67**.If yes, indicate location(s) | 🞎cortex 🞎subcortex 🞎basal ganglia 🞎thalamus 🞎unknown |
|  | **68**. If yes, did any lesions  enhance with GAD? | 🞎yes 🞎no 🞎unknown |
| **69.** Any **brainstem** lesions? | 🞎yes 🞎no 🞎unknown |  |
|  | **70**. If yes, indicate location: | 🞎midbrain 🞎pons 🞎medulla 🞎unknown |
|  | **71**. If yes, did any lesions  enhance with GAD? | 🞎yes 🞎no 🞎unknown |
| **72.** Any **cranial nerve** lesions? | 🞎yes 🞎no 🞎unknown |  |
|  | **73**. If yes, indicate which  CN(s): | CN\_\_\_\_\_ 🞎unilateral 🞎bilateral CN\_\_\_\_\_ 🞎unilateral 🞎bilateral |
|  |  | CN\_\_\_\_\_ 🞎unilateral 🞎bilateral CN\_\_\_\_\_ 🞎unilateral 🞎bilateral |
|  | **74**. If yes, did any lesions  enhance with GAD? | 🞎yes 🞎no 🞎unknown |
| **75**. Any lesions affecting the  **cerebellum**? | 🞎yes 🞎no 🞎unknown |  |

**76. Was an EMG done**?🞎yes 🞎no 🞎unknown If yes, date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ *(mm/dd/yyyy)*

**77.** If yes, was there evidence of acute motor neuropathy, motor neuronopathy, motor nerve or anterior horn cell involvement?🞎yes 🞎no 🞎unkn

**CSF examination: 78**. Was a lumbar puncture performed? 🞎yes 🞎no 🞎unknown If yes, complete 79 (*If more than 2 CSF 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 |
| **79a.** **CSF** from LP1 |  |  |  |  |  |  |  |  |  |
| **79b.** **CSF** from LP2 |  |  |  |  |  |  |  |  |  |

**Pathogen testing performed:**

|  |  |
| --- | --- |
| **80**. Was **CSF** testedfor the following pathogens? | Date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ 🞎 Not done |
|  | Enterovirus PCR: 🞎 Positive 🞎 Negative 🞎 Not done  If positive: type: 🞎 Not typed |
|  | West Nile Virus PCR: 🞎 Positive 🞎 Negative 🞎 Not done  If positive, test type: 🞎 IgM 🞎 PCR |
|  | Herpes Simplex Virus PCR: 🞎 Positive 🞎 Negative 🞎 Not done |
|  | Cytomegalovirus PCR: 🞎 Positive 🞎 Negative 🞎 Not done |
|  | Varicella Zoster Virus PCR: 🞎 Positive 🞎 Negative 🞎 Not done |
|  | Other pathogen identified: specify:  Type of test: |

Page 4 of 6

Page 4 of 6

CDC ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **81**. Wasa **respiratory tract specimen** tested for the following pathogens? | Date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ 🞎 Not done |
|  | Enterovirus/rhinovirus PCR: 🞎 Positive 🞎 Negative 🞎 Not done  If positive: type: 🞎 Not typed |
|  | Adenovirus PCR: 🞎 Positive 🞎 Negative 🞎 Not done  If positive: type: 🞎 Not typed |
|  | Influenza virus PCR: 🞎 Positive 🞎 Negative 🞎 Not done  If positive: type: 🞎 Not typed |
|  | Other pathogen identified: specify:  Type of test: |

|  |  |
| --- | --- |
| **82.** Wasa **stool specimen** tested forthe following pathogens? | Date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ 🞎 Not done |
|  | Enterovirus PCR: 🞎 Positive 🞎 Negative 🞎 Not done  If positive: type: 🞎 Not typed |
|  | Poliovirus PCR: 🞎 Positive 🞎 Negative 🞎 Not done |
|  | Poliovirus culture: 🞎 Positive 🞎 Negative 🞎 Not done |
|  | Other pathogen identified: specify:  Type of test: |

|  |  |
| --- | --- |
| **83.** Was **serum** tested for the following pathogens? | Date of specimen collection \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ 🞎 Not done |
|  | West Nile Virus: 🞎 Positive 🞎 Negative 🞎 Not done  If positive, test type: 🞎 IgM 🞎 PCR |
|  | Other pathogen identified: specify:  Type of test: |

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**85.** Was/Is a **specific etiology** considered to be the most likely cause for the patient’s neurological illness? 🞎yes 🞎no 🞎unknown **86.** If yes, please list etiology and reason(s) considered most likely cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment: 87.** Were any of these therapies administered for the acute neurologic illness? (as of time of form completion)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Unknown |  |
| a. Antibiotics |  |  |  | If yes, date first administered: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ |
| b. Antivirals |  |  |  | If yes, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; date first administered: \_\_ \_\_/\_\_ \_\_/ |
| c. Corticosteroids |  |  |  | If yes, date first administered: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ |
| d. Intravenous immune globulin (IVIG) |  |  |  | If yes, date first administered: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ |
| e. Plasma exchange or Plasmapheresis |  |  |  | If yes, date first administered: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ |
| f. Interferon |  |  |  | If yes, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; date first administered: \_\_ \_\_/\_\_ \_\_/ |
| **g**. Other immunosuppressive therapy |  |  |  | If yes, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; date first administered: \_\_ \_\_/\_\_ \_\_/ |

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 5 of 6

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**89.** 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 🞎 Other, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 No specimens stored

-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

***This section below for CDC use***

|  |  |  |
| --- | --- | --- |
| CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | CSID (DASH ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Patient Number (assigned by CDC PPLB Lab)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | State Specimen ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Other specimen notes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

Page 6 of 6

Page 6 of 6