

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

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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

| 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) | <input type="checkbox"/> Areflexic/hyporeflexic (0-1) <input type="checkbox"/> Normal (2) <input type="checkbox"/> 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 |
| 29. Sensory level on the torso (ie, reduced sensation below a certain level of the torso)? (at any time during illness) | | | | Unknown |
| 30. At any time during the illness, please check if the patient had any of the following cranial nerve signs: | | | | |
| <input type="checkbox"/> Diplopia/double vision (If yes, circle the cranial nerve involved if known: 3 / 4 / 6) | | | | |
| <input type="checkbox"/> Loss of sensation in face <input type="checkbox"/> Facial droop <input type="checkbox"/> Hearing loss <input type="checkbox"/> Dysphagia <input type="checkbox"/> 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) | | | | |

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333;

| | | | |
|--|--------|--|--|
| 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) | CDC ID | | |
| 37. Received invasive ventilatory support (e.g, intubation, tracheostomy) because of neu | | | |

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 $\geq 38.0^{\circ}\text{C}/100.4^{\circ}\text{F}$? | | | | 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 | <input type="checkbox"/> 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 | <input type="checkbox"/> 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 | <input type="checkbox"/> 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: | <input type="checkbox"/> cervical cord <input type="checkbox"/> conus <input type="checkbox"/> unknown | <input type="checkbox"/> thoracic cord <input type="checkbox"/> cauda equina | Levels of cord affected (if applicable): 57. Cervical: _____ 58. Thoracic: _____ |
| For cervical and thoracic cord lesions | 59. What areas of spinal cord were affected? | <input type="checkbox"/> predominantly gray matter <input type="checkbox"/> both equally affected | <input type="checkbox"/> predominantly white matter <input type="checkbox"/> unknown |
| | 60. Was there cord edema? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | |
| For cervical, thoracic cord or conus lesions | 61. Did any lesions enhance with GAD? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | |
| For cauda equina lesions | 62. Did the ventral nerve roots enhance with GAD? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | |
| | 63. Did the dorsal nerve roots enhance with GAD? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | |

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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, yes no unknown

| | | |
|---|---|--|
| or thalamic) lesions | | |
| | 67. If yes, indicate location(s) | <input type="checkbox"/> cortex <input type="checkbox"/> subcortex <input type="checkbox"/> basal ganglia <input type="checkbox"/> thalamus <input type="checkbox"/> unknown |
| | 68. If yes, did any lesions enhance with GAD? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 69. Any brainstem lesions? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | |
| | 70. If yes, indicate location: | <input type="checkbox"/> midbrain <input type="checkbox"/> pons <input type="checkbox"/> medulla <input type="checkbox"/> unknown |
| | 71. If yes, did any lesions enhance with GAD? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 72. Any cranial nerve lesions? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | |
| | 73. If yes, indicate which CN(s): | CN _____ <input type="checkbox"/> unilateral <input type="checkbox"/> bilateral CN _____ <input type="checkbox"/> unilateral <input type="checkbox"/> bilateral |
| | | CN _____ <input type="checkbox"/> unilateral <input type="checkbox"/> bilateral CN _____ <input type="checkbox"/> unilateral <input type="checkbox"/> bilateral |
| | 74. If yes, did any lesions enhance with GAD? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 75. Any lesions affecting the cerebellum? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> 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 tested for the following pathogens? | Date of specimen collection __/__/____ <input type="checkbox"/> Not done |
| | Enterovirus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done If positive: type: <input type="checkbox"/> Not typed |
| | West Nile Virus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done If positive, test type: <input type="checkbox"/> IgM <input type="checkbox"/> PCR |
| | Herpes Simplex Virus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done |
| | Cytomegalovirus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done |
| | Varicella Zoster Virus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done |
| | Other pathogen identified: specify: Type of test: |

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| | |
|---|--|
| 81. Was a respiratory tract specimen tested for the following pathogens? | Date of specimen collection ____/____/____ <input type="checkbox"/> Not done |
| | Enterovirus/rhinovirus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done If positive: type: _____ <input type="checkbox"/> Not typed |
| | Adenovirus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done If positive: type: _____ <input type="checkbox"/> Not typed |
| | Influenza virus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done If positive: type: _____ <input type="checkbox"/> Not typed |
| | Other pathogen identified: specify: _____ Type of test: _____ |

| | |
|---|---|
| 82. Was a stool specimen tested for the following pathogens? | Date of specimen collection ____/____/____ <input type="checkbox"/> Not done |
| | Enterovirus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done If positive: type: _____ <input type="checkbox"/> Not typed |
| | Poliovirus PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done |
| | Poliovirus culture: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done |
| | Other pathogen identified: specify: _____ Type of test: _____ |

| | |
|--|---|
| 83. Was serum tested for the following pathogens? | Date of specimen collection ____/____/____ <input type="checkbox"/> Not done |
| | West Nile Virus: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done If positive, test type: <input type="checkbox"/> IgM <input type="checkbox"/> 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 _____

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) _____

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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 _____
