**Acute Flaccid Myelitis: Patient Summary Form**

**FOR LOCAL USE ONLY**

Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State assigned patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of main hospital that provided patient’s care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***-------------------------------------------------------------DETACH and transmit only lower portion to*** ***limbweakness@cdc.gov*** ***if sending to CDC-------------------------------------------------------------***

Form Approved

OMB No. 0920-0009

Exp Date: 04/30/2016

 **Acute Flaccid Myelitis: 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**. State assigned patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** Sex: 🞎 M 🞎F **4.** Date of birth \_\_ \_\_/ \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_ Residence: **5**. State\_\_\_\_\_\_\_ **6.** County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7**. Race: 🞎American Indian or Alaska Native 🞎Asian 🞎Black or African American **8**. Ethnicity: 🞎Hispanic or Latino

 🞎Native Hawaiian or Other Pacific Islander 🞎White *(check all that apply)* 🞎Not Hispanic or Latino

**9.** Date of onset of limb weakness \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ *(mm/dd/yyyy)* **10**. Was patient admitted to a hospital? 🞎yes 🞎no 🞎unknown **11.**Date of admission to **first** hospital\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ **12.**Date of discharge from **last** hospital\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_(or 🞎 still hospitalized at time of form submission)

**13**. Did the patient die from this illness? 🞎yes 🞎no 🞎unknown **14**. If yes, date of death\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_

|  |
| --- |
| **SIGNS/SYMPTOMS/CONDITION:**  |
|  | Right Arm | Left Arm | Right Leg | Left Leg |
| **15**. 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 |
| **16.** Date of neurologic exam (recorded at most severe weakness to point of completing this form) *(mm/dd/yyyy)* | \_\_ \_\_ /\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| **17**. At the time of most severe weakness, reflexes in the **most** **affected** limb(s):  | 🞎 Areflexic/hyporeflexic (0-1) 🞎 Normal (2) 🞎 Hyperreflexic (3-4+) |
| **At ANY time during the illness, was there:** |  |
| **18**. Any sensory loss/numbness in the **affected** limb(s), at any time during the illness? (paresthesias should not be considered here) | Y N U |
| **19**. Any pain or burning in the **affected** limb(s)?  | Y N U |
|  | Yes | No | Unk/Not Recorded (NR) |
| **20.** Sensory level on the torso (i.e., reduced sensation below a certain level of the torso)?  |  |  |  |
| **21.** Did patient have any of the cranial nerve features below? (If yes, check all that apply): |  |  |  |
|  🞎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  |
| **22**. Bowel or bladder incontinence?  |  |  |  |
| **23.** Change in mental status (e.g., confused, disoriented, encephalopathic)?  |  |  |  |
| **24**. Seizure(s)?  |  |  |  |
| **25**. Receipt of positive pressure ventilation, including invasive or non-invasive ventilation and including BiPAP or CPAP? |  |  |  |

**Other patient information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| In the 4-weeks **BEFORE onset** of **limb weakness**, did patient: | Yes | No | Unk/NR |  |
|  **26**. Have a respiratory illness? |  |  |  | **27**. If yes, onset date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_  |
| 28. Have a gastrointestinal illness (e.g., diarrhea or vomiting)? |  |  |  | 29. If yes, onset date \_\_ \_\_/\_\_ \_\_/ \_\_ \_\_ \_\_ \_\_ |
| 30. Have a new onset rash? |  |  |  | 31. If yes, onset date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
|  **32**. Have a fever, measured by parent or provider and ≥ 38.0°C/100.4°F?  |  |  |  | **33**. If yes, onset date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_  |
|  |
| **34.** Receive any immunosuppressing agent(s) (BEFORE WEAKNESS ONSET)? |  |  |  | Form ApprovedOMB No. 0920-0009Exp Date: 04/30/2016**35.** If yes: Date of first administration: \_\_ \_\_/ \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mode of administration: 🞎IM 🞎IV 🞎OralDosage / duration / overall amount administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **36.** Travel outside the US? |  |  |  | **37.** If yes, list country: |
|  **38**. At onset of limb weakness, does patient have any underlying illnesses? |  |  |  | **39.** If yes, list: |
|  **40.** **On the day of onset of limb weakness**, did patient have a fever?  |  |  |  | (see definition for fever above in 32.) |

|  |
| --- |
| **Polio vaccination history:** |
| **41**. How many doses of **inactivated polio vaccine (IPV**) are **documented** to have been received by  the patient before the onset of weakness? | \_\_\_\_\_\_\_doses 🞎unknown |
| **42.** How many doses of **oral polio vaccine (OPV)** are **documented** to have been received by the  patient before the onset of weakness? | \_\_\_\_\_\_\_doses 🞎unknown |
| **43.** If you do not have documentation of the *type* of polio vaccine received what is total number of **documented** polio vaccine doses received before onset of weakness?  | \_\_\_\_\_\_\_doses 🞎unknown |

**Neuroradiographic findings**:

**MRI of spinal cord** **44.** Was MRI of spinal cord performed? 🞎 yes 🞎no 🞎 unknown

**45**. If yes, how many documented spinal MRIs were performed? \_\_\_\_\_\_\_\_

*If yes to Q44, complete Q46-Q71 based on* ***most abnormal spine MRI*** **46.** Date of most abnormal spine MRI \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

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

|  |  |  |
| --- | --- | --- |
| **48.** Location of lesions: | 🞎cervical cord 🞎thoracic cord 🞎conus 🞎cauda equina 🞎unknown | Levels of cord affected (if applicable):**49**. Cervical: \_\_\_\_\_\_\_\_\_ **50.** Thoracic: \_\_\_\_\_\_\_\_\_ |
| For **cervical and thoracic** **cord** lesions | **51.** What areas of spinal cord were  affected? | 🞎predominantly gray matter 🞎predominantly white matter 🞎both equally affected 🞎 unknown |
|  | **52**. Was there cord edema? | 🞎 yes 🞎no 🞎 unknown  |
| **53.** Gadolinium (GAD) used: 🞎yes 🞎no 🞎 unknown ***(If NO, skip to question 59)*** |
| For **cervical, thoracic cord or conus** lesions | **54**. Did any **gray** matter lesions enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |
|  | **55**. Did any **white** matter lesions enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |
|  | **56.** Did any cervical / thoracic nerve roots enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |
| For **cauda equina** lesions | **57**. Did the **ventra**l nerve roots  enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |
|  | **58**. Did the **dorsal** nerve roots  enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |

**MRI of brain**

**59.** Was brain/brainstem/cerebellum MRI performed? 🞎 yes 🞎no 🞎 unknown (*If NO, skip to Q72*) **60.** Date of study \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

|  |  |  |
| --- | --- | --- |
| **61**. Any **supratentorial** (i.e, lobe, cortical, subcortical, basal ganglia, or thalamic) lesions | 🞎 yes 🞎 no 🞎 unknown  |  |
|  | **62**.If yes, indicate location(s)  | 🞎cortex 🞎basal ganglia 🞎thalamus 🞎 subcortex 🞎unknown🞎Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **63.** Any **brainstem** lesions?  | 🞎 yes 🞎 no 🞎 unknown  |  |
|  | **64**. If yes, indicate location:  | 🞎midbrain 🞎pons 🞎medulla 🞎unknown |
| **65.** Any **cranial nerve** lesions? | 🞎 yes 🞎 no 🞎 unknown  |  |
|  | **66**. If yes, indicate which  CN(s): | CN\_\_\_\_\_ 🞎unilateral 🞎bilateral CN\_\_\_\_\_ 🞎unilateral 🞎bilateral  |
|  |  | CN\_\_\_\_\_ 🞎unilateral 🞎bilateral CN\_\_\_\_\_ 🞎unilateral 🞎bilateral  |
| **67**. Any lesions affecting the **cerebellum**? | 🞎 yes 🞎 no 🞎 unknown  |  |
| **68.** Gadolinium (GAD) used: 🞎 yes 🞎 no 🞎 unknown ***(If NO, skip to question 72)*** |
| **69.** Did any supratentorial lesions enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |  |
| **70.** Did any brainstem lesions enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |  |
| **71.** Did any cranial nerve lesions enhance with GAD? | 🞎 yes 🞎 no 🞎 unknown  |  |

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

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

**CSF examination: 74**. Was a lumbar puncture performed? 🞎 yes 🞎 no 🞎 unknown

If yes, complete 74 (a,b) (*If more than 2 CSF examinations, list the first 2 performed)*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Date of lumbar puncture | WBC/mm3 | % neutrophils | % lymphocytes | % monocytes | % eosinophils | RBC/mm3 | Glucose mg/dl | Protein mg/dl |
| **74a.** **CSF** from LP1 |  |  |  |  |   |  |  |  |  |
| **74b.** **CSF** from LP2 |  |  |  |  |  |  |  |  |  |

**Pathogen testing performed:**

|  |
| --- |
| **75**. **Was CSF tested?** 🞎 yes 🞎 no 🞎 unknown  **Specimen Collection Date \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_** **If ‘yes’, was specimen tested for the following:** |
|  | Enterovirus🞎 yes 🞎 no 🞎 unknown | **Test Type** | **Test Result** | **Typed (if positive)?** | **Type** |
| PCR | 🞎 Positive 🞎 Negative 🞎 Pending | 🞎 yes 🞎 no 🞎 not done | \_\_\_\_\_\_\_ |
| West Nile Virus🞎 yes 🞎 no 🞎 unknown | PCR | 🞎 Positive 🞎 Negative 🞎 Pending |  |  |
| West Nile Virus🞎 yes 🞎 no 🞎 unknown | IgM | 🞎 Positive 🞎 Negative 🞎 Indeterminate 🞎Pending 🞎 Unknown |
| Herpes simplex virus🞎 yes 🞎 no 🞎 unknown | PCR | 🞎 Positive 🞎 Negative 🞎 Pending |
| Cytomegalovirus🞎 yes 🞎no 🞎 unknown | PCR | 🞎 Positive 🞎 Negative 🞎 Pending |
| Varicella zoster virus🞎 yes 🞎 no 🞎 unknown | PCR | 🞎 Positive 🞎 Negative 🞎 Pending |
| Was other pathogen identified:🞎 yes 🞎 no 🞎 unknown  | If positive for other pathogen, specify test type:\_\_\_\_\_\_\_\_\_\_\_\_\_ | List other pathogen(s) identified:  |  |  |
|  |  |
| **76**. **Was a RESPIRATORY TRACT specimen tested**? 🞎 yes 🞎 no 🞎 unknown  **Specimen Collection Date \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_** **Type of specimen:** 🞎 nasopharyngeal swab 🞎 nasal wash/aspirate 🞎 oropharyngeal swab 🞎 other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **If ‘yes’, was specimen tested for the following:** |
|   | Enterovirus/rhinovirus🞎 yes 🞎 no 🞎 unknown | **Test Type** | **Test Result** | **Typed (if positive)?** | **Type** |
| PCR  | 🞎 Positive 🞎 Negative 🞎 Pending | 🞎 yes 🞎 no 🞎 not done | \_\_\_\_\_\_\_ |
| Adenovirus🞎 yes 🞎 no 🞎 unknown  | PCR | 🞎 Positive 🞎 Negative 🞎 Pending | 🞎 yes 🞎 no 🞎 not done | \_\_\_\_\_\_\_ |
| Influenza virus 🞎 yes 🞎 no 🞎 unknown | PCR | 🞎 Positive 🞎 Negative 🞎 Pending | 🞎 yes 🞎 no 🞎 not done | \_\_\_\_\_\_\_ |
| Was other pathogen identified:🞎 yes 🞎 no unknown | If positive for other pathogen, specify test type:\_\_\_\_\_\_\_\_\_\_\_\_\_ | List other pathogen(s) identified:  |  |  |
|  |  |
| **77.** **Was a STOOL specimen tested?** 🞎 yes 🞎 no 🞎 unknown **Specimen Collection Date \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_** **If ‘yes’, was specimen tested for the following:** |
|  | Non-polio Enterovirus 🞎 yes 🞎 no 🞎 unknown  | **Test Type** | **Test Result** | **Typed (if positive)?** | **Type** |
| PCR | 🞎 Positive 🞎 Negative 🞎 Pending | 🞎 yes 🞎 no 🞎 not done | \_\_\_\_\_\_\_ |
| Poliovirus 🞎 yes 🞎 no 🞎 unknown |  PCR | 🞎 Positive 🞎 Negative 🞎 Pending |  |  |
| Poliovirus 🞎 yes 🞎 no 🞎 unknown | Culture | 🞎 Positive 🞎 Negative 🞎 Pending |  |  |
| Was other pathogen identified:🞎 yes 🞎 no unknown | If positive for other pathogen, specify test type:\_\_\_\_\_\_\_\_\_\_\_\_\_ | List other pathogen(s) identified:  |  |  |
|  |
| **78.** **Was SERUM tested?** 🞎 yes 🞎 no 🞎 unknown **Specimen Collection Date \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_** **If ‘yes’, was specimen tested for the following:** |
|  | West Nile Virus 🞎 yes 🞎 no 🞎 unknown  | **Test Type** | **Test Result** | **Typed (if positive)?** | **Type** |
| PCR | 🞎 Positive 🞎 Negative 🞎 Pending |  |  |
| West Nile Virus 🞎 yes 🞎 no 🞎 unknown  | IgM | 🞎 Positive 🞎 Negative 🞎 Indeterminate 🞎Pending 🞎 Unknown |
| Was other pathogen identified:🞎 yes 🞎 no unknown | If positive for other pathogen, specify test type:\_\_\_\_\_\_\_\_\_\_\_\_\_ | List other pathogen(s) identified:  |  |  |

**79.** Was/Is a **specific etiology** considered to be the most likely cause for the patient’s neurological illness? 🞎 yes 🞎 no 🞎 unknown **80**. **If yes**, please list etiology and reason(s) considered most likely cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**81.** If patient is a confirmed or probable case, will specimens be sent to CDC for testing? 🞎 yes 🞎 no 🞎 unknown

**82.** **If yes**, types of specimens that will be sent to CDC for testing:

 🞎 CSF 🞎 Nasal wash/aspirate 🞎BAL spec 🞎Tracheal aspirate 🞎NP/OP swab 🞎Stool 🞎Serum 🞎 Other, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acute Flaccid Myelitis case definition** (<http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/2015PS/2015PSFinal/15-ID-01.pdf>)

**Criteria**

An illness with onset of acute focal limb weakness AND

● a magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments, OR

● no spinal cord MRI performed but cerebrospinal fluid (CSF) with pleocytosis (white blood cell count >5 cells/mm3)

**Case Classification**

***Confirmed:***

**●** An illness with onset of acute focal limb weakness AND

● MRI showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments

***Probable:***

**●** An illness with onset of acute focal limb weakness AND

● No spinal cord MRI performed but CSF showing pleocytosis (white blood cell count >5 cells/mm3).