**Undetermined agent, source, mode of transmission, and risk factors for Guillain-Barré Syndrome in the setting of Zika virus transmission— Colombia, 2016**

**Chart Abstraction Form**

*The ID number begins with the 2 digit case number (for example COL-01). Information as documented by attending physician.*

***The following pages are to be abstracted from the medical records / exam:***

Chart Abstractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abstraction Date: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_

MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MM DD YYYY

1. First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Paternal name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maternal name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Age (years): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
    MM DD YYYY
4. Sex: □ Male □Female
5. Patient address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Patient zip code: \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_
7. Patient phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Date of neuro symptom onset: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_ Date first sought care: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
    MM DD YYYY MM DD YYYY

Date of admission: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_ Date of discharge/death: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY MM DD YYYY

1. Discharged to:

□ Home □ Rehab/skilled nursing facility □ Transferred □ Died □ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_

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| CURRENT ILLNESS |

1. How long from onset until hospital admission? \_\_\_\_\_\_\_\_\_\_minutes/hours/days/weeks
2. What were the initial neurologic symptoms (i.e. within the three days of illness onset)? (check all that apply, signs from PE, symptoms from HPI)

□ Leg weakness □ Arm weakness □ Diplopia/Ophthalmoplegia

□ Leg numbness/paresthesias □ Arm numbness/paresthesias □ Face numbness/paresthesias

□ SOB / respiratory distress □ Gait imbalance (not weakness)/ataxia □ Hand clumsiness/ataxia  
 □ Hyporeflexia/areflexia □ Face weakness □ Dysarthria □ Dysphagia □ Dysautonomia

1. What neurologic symptoms occurred AT ANY TIME during the neuro illness? (check all that apply, signs from PE, symptoms from HPI)

□ Leg weakness □ Arm weakness □ Diplopia/Ophthalmoplegia

□ Leg numbness/paresthesias □ Arm numbness/paresthesias □ Face numbness/paresthesias

□ SOB / respiratory distress □ Gait imbalance (not weakness)/ataxia □ Hand clumsiness/ataxia  
 □ Hyporeflexia/areflexia □ Face weakness □ Dysarthria □ Dysphagia □ Dysautonomia

1. How long from onset until maximum/worst neuro symptoms? \_\_\_\_\_\_\_\_\_\_\_\_ minutes/hours/days/weeks
2. At the worst point during this neuro illness, check all that apply for the patient:

□ Unable to walk without assistance (e.g. cane, walker) □ Unable to walk at all

□ Admitted to the hospital □ Admitted to the ICU/CCU □ Intubated

1. If any blood was taken for this neurologic illness, please fill out the following for the INITIAL blood draw:

Date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_ WBC \_\_\_\_ HgB\_\_\_\_ Plts \_\_\_\_\_ Na \_\_\_\_ K\_\_\_\_  
 MM DD YYYY

BUN \_\_\_\_ Cr \_\_\_\_\_\_ Glucose\_\_\_\_ TBili\_\_\_\_ AST \_\_\_\_ ALT\_\_\_\_ AlkPhos \_\_\_

1. Was there documented hyporeflexia/areflexia? □ Yes □ No □ Unknown
2. Was there documentation of upper motor neuron signs?

□ Hyperreflexia □ Increased tone/spasticity □ Babinski/Hoffman □ Sustained clonus

1. Was there any sensory level documented? □ Yes □ No □ Unknown

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| LABORATORY, IMAGING, AND ELECTROPHYSIOLOGIC STUDIES |

1. Was a lumbar puncture (LP) done? □ Yes □ No □ Unknown

LP date \_\_\_/\_\_\_\_/\_\_\_\_ RBCS \_\_\_\_\_\_\_ WBCS \_\_\_\_\_\_ Protein (mg/dL)\_\_\_\_\_\_ Glucose (mg/dL) \_\_\_\_\_\_\_  
 MM DD YYYY

Differential\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_IgG index\_\_\_\_\_\_ Oligoclonal bands\_\_\_\_\_\_ IgG synthesis\_\_\_\_\_\_\_\_\_\_\_

LP date \_\_\_/\_\_\_\_/\_\_\_\_ RBCS \_\_\_\_\_\_\_ WBCS \_\_\_\_\_\_ Protein (mg/dL)\_\_\_\_\_\_ Glucose (mg/dL) \_\_\_\_\_\_\_  
 MM DD YYYY

Differential\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_IgG index\_\_\_\_\_\_ Oligoclonal bands\_\_\_\_\_\_ IgG synthesis\_\_\_\_\_\_\_\_\_\_\_

1. Did they receive any targeted treatment (IVIG/steroids/plasma exchange) for this neuro illness?

IVIG □ Yes □ No □ Unknown Start date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY  
Plasma exchange □ Yes □ No □ Unknown Start date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY

Steroids □ Yes □ No □ Unknown Start date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY  
Mechanical ventilation □ Yes □ No □ Unknown Start date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY

Other □ Yes □ No □ Unknown Start date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY

1. Did the patient receive blood transfusion/blood products? (other than IVIG)

□ Yes □ No □ Unknown which one\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY

1. Were any of the following diseases tested for? If so, what was the result? (including specimen and type of test)

a. *Campylobacter jejuni* □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. *Mycoplasma pneumoniae* □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. *Haemophilus influenzae* □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. *Salmonella spp.* □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Cytomegalovirus (CMV) □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f. Epstein-Barr virus (EBV) □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

g. Varicella-zoster virus (VZV) □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

h. Human immunodeficiency virus (HIV) □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i. Enterovirus / Rhinovirus □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
j. Arboviruses □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

k. Other □ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Was neuro imaging done? If so, what was the result? (Transcribe the impression)

□ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_

MM DD YYYY

1. Were electro-diagnostics done (e.g. EMG)? If so, what were the results? (Transcribe the impression)

□ Yes □ No Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_

MM DD YYYY

1. What was the GBS Brighton level? 1 2 3 4 5

Levels of Diagnostic Certainty

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Level 1*** | ***Level 2*** | ***Level 3*** | ***Level 4\**** | ***Level 5*** |
| Absence of an alternative diagnosis for weakness | | | | NOT a case |
| Acute onset of bilateral and relatively symmetric flaccid weakness of the limbs | | | \* Lacking documentation to fulfill minimal case criteria |
| Decreased or absent deep tendon reflexes in affected limbs | | |
| Monophasic illness pattern with weakness nadir between 12 hours and 28 days, followed by clinical plateau | | |
| Albuminocytologic dissociation (elevation of CSF protein level above laboratory normal value and CSF total white cell count < 50 cells/mm3) | CSF with a total white cell count < 50 cells/mm3 (with or without CSF protein elevation above laboratory normal value) or if CSF not collected or results not available, and electrodiagnostic studies consistent with GBS |  |
| Electrophysiologic findings consistent with GBS |  |  |

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| ANTECEDENT ILLNESS |

1. **a.)** In the 2 months prior to neuro onset date, did the individual experience an acute illness? (other than their neuro illness)? □ Yes □No □ Unknown

**b.)** How long from prior acute illness onset until admission for neuro illness? \_\_\_\_\_\_\_\_\_ minutes/hours/days/weeks

1. **a.)** What symptoms did they report having or what signs were noticed? (check all that apply)

□ Fevers □ Chills □ Nausea or Vomiting □ Diarrhea □ Muscle pains □ Joint pains □ Skin rash □ Conjunctivitis

□ Headache □ Pain behind eyes □ Stiff neck □ Confusion

□ Back pain □ Abdominal pain □ Coughing □ Runny nose

□ Sore throat □ Calf pain □ Pruritis

**b.)** If any blood was taken for this acute illness, please fill out the following for the INITIAL blood draw:

Date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_ WBC \_\_\_\_ HgB\_\_\_\_ Plts \_\_\_\_\_ Na \_\_\_\_ K\_\_\_\_   
 DD MM YYYY

BUN \_\_\_\_ Cr \_\_\_\_\_\_ Glucose\_\_\_\_ TBili\_\_\_\_ AST \_\_\_\_ ALT\_\_\_\_ AlkPhos \_\_\_

**c.)** Were they hospitalized for this acute illness? □ Yes □ No □ Unknown

**d.)** Did they receive any blood products / IVIG for this illness? □ Yes □ No □ Unknown

What product? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date? \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY

**e.)** Did they receive plasmapheresis / plasma exchange for this illness? □ Yes □ No □ Unknown

If yes, date? \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_  
 MM DD YYYY

1. Is there a test result available for dengue from this medical visit? □ Yes □ No □ Unknown

If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there a test result available for chikungunya from this medical visit? □ Yes □ No □ Unknown

If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there a test result available for Zika from this medical visit? □ Yes □ No □ Unknown

If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| PAST MEDICAL, SOCIAL AND FAMILY HISTORY |

1. What medical conditions are listed in the admission history and physical (H&P)?

□ Hypertension □ Diabetes □ HIV □ Autoimmune disorder\_\_\_\_\_\_\_\_\_\_\_\_

□ Prior GBS □ Hemoglobinopathy □ B12 deficiency □ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What social conditions are listed in admission H&P?

□ Alcohol use □ Drug use □ Tobacco □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What conditions are listed in family history of H&P?

□ Autoimmune disorder (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cancer (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hemoglobinopathy (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Neuro (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_