Form Approved
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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

Public reporting burden of this collection of information is estimated to average 60 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; ATTN: PRA (0920-1011)

Study ID Number COL-____ ____ Encounter level (Brighton 1-5) or not neuro (6): ____

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: __ __ /__ __ /________ MM DD YYYY Date first sought care: __ __ /__ __ /________ MM DD YYYY

   Date of admission: __ __ /__ __ /________ MM DD YYYY Date of discharge/death: __ __ /__ __ /________ MM DD YYYY

9. Discharged to:

   ☐ Home ☐ Rehab/skilled nursing facility ☐ Transferred ☐ Died ☐ Other (specify) ______________

CURRENT ILLNESS

10. How long from onset until hospital admission? ___________minutes/hours/days/weeks

11. 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

12. 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

Study ID Number COL-____ ____ Encounter level (Brighton 1-5) or not neuro (6): ____

13. How long from onset until maximum/worst neuro symptoms? ____________ minutes/hours/days/weeks

14. 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

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

Date __ __ /__ __ /_______ (MM DD YYYY) WBC ____ HgB____ Plts _____ Na ____ K____

BUN ____ Cr ______ Glucose____ TBili____ AST ____ ALT____ AlkPhos ___

16. Was there documented hyporeflexia/areflexia? ☐ Yes ☐ No ☐ Unknown

17. Was there documentation of upper motor neuron signs?

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

18. Was there any sensory level documented? ☐ Yes ☐ No ☐ Unknown

LABORATORY, IMAGING, AND ELECTROPHYSIOLOGIC STUDIES

19. Was a lumbar puncture (LP) done? ☐ Yes ☐ No ☐ Unknown

LP date ___/____/____ (MM DD YYYY) RBCS _______ WBCS ______ Protein (mg/dL)______ Glucose (mg/dL) _______

Differential________________________IgG index______ Oligoclonal bands______ IgG synthesis___________

LP date ___/____/____ (MM DD YYYY) RBCS _______ WBCS ______ Protein (mg/dL)______ Glucose (mg/dL) _______

Differential________________________IgG index______ Oligoclonal bands______ IgG synthesis___________

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

		Start date
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)

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

☐ Yes ☐ No ☐ Unknown which one_________________ Start date __ __ /__ __ /________
MM DD YYYY

22. 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:____________________________

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

☐ Yes ☐ No Result:____

____ Date __ __ /__ __ /________
MM DD YYYY

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

☐ Yes ☐ No Result:____

____ Date __ __ /__ __ /________
MM DD YYYY

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

Levels of Diagnostic Certainty

<table>
<tr><th>Level 1</th><th>Level 2</th><th>Level 3</th><th>Level 4*</th><th>Level 5</th></tr>
<tr><td colspan="4">Absence of an alternative diagnosis for weakness</td><td rowspan="6">NOT a case</td></tr>
<tr><td colspan="3">Acute onset of bilateral and relatively symmetric flaccid weakness of the limbs</td><td rowspan="5">* Lacking documentation to fulfill minimal case criteria</td></tr>
<tr><td colspan="3">Decreased or absent deep tendon reflexes in affected limbs</td></tr>
<tr><td colspan="3">Monophasic illness pattern with weakness nadir between 12 hours and 28 days, followed by clinical plateau</td></tr>
<tr><td>Albuminocytologic dissociation (elevation of CSF protein level above laboratory normal value and CSF total white cell count < 50 cells/mm^3)</td><td>CSF with a total white cell count < 50 cells/mm^3 (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</td><td></td></tr>
<tr><td>Electrophysiologic findings consistent with GBS</td><td></td><td></td></tr>
</table>

ANTECEDENT ILLNESS

26. **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

27. **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 __ __ /__ __ /________ (DD MM YYYY) WBC ____ HgB____ Plts _____ Na ____ K____

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)

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

If yes, please specify:_______________________________________

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

If yes, please specify:_______________________________________

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

If yes, please specify:_______________________________________

PAST MEDICAL, SOCIAL AND FAMILY HISTORY

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

☐ Hypertension ☐ Diabetes ☐ HIV ☐ Autoimmune disorder____________

☐ Prior GBS ☐ Hemoglobinopathy ☐ B12 deficiency ☐ Cancer ________________________

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

☐ Alcohol use ☐ Drug use ☐ Tobacco ☐ Other __________________________

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

☐ Autoimmune disorder (specify)____________________ ☐ Cancer (specify) _____________________

☐ Hemoglobinopathy (specify) ______________________ ☐ Neuro (specify) _____________________