**Chart Abstraction Questionnaire for the Investigation of Severe Neurologic Illness**

**in Relation to Arboviral Infections**

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

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

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 admission: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_ Date first sought care: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_
 MM DD YYYY MM DD YYYY

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

1. Discharged to:

□ Home (with outpatient PT: Yes / No) □ Rehab/skilled nursing facility □ Hospice

□ Transferred (specify hospital) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Died □ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Health insurance: □ Reforma/SSS □ Private □ Veteran’s □ None □ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT ILLNESS**

1. How long from onset until hospital admission? \_\_\_\_\_\_\_\_\_\_minutes/hours/days/weeks

1. What were the initial neurologic symptoms within the three days prior to 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 □ Dysarthria □ Dysphagia □ Dysautonomia

 □ Face weakness (circle: unilateral or bilateral)

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 □ Dysarthria □ Dysphagia □ Dysautonomia

 □ Face weakness (circle: unilateral or bilateral

1. Were motor deficits present? □ Yes □ No □ Unknown If so, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Date of maximum/worst neuro symptoms: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_

 MM DD YYYY

1. At the worst point during this neuro illness, check all that apply for the patient:

 □ Unable to walk without assistance □ Unable to walk at all □ Admitted to the hospital □ Admitted to the ICU/CCU □ Intubated □ Coma

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
2. 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

 Acyclovir □ 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 If so, which: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start date \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_
 MM DD YYYY

**LABORATORY, IMAGING, AND ELECTROPHYSIOLOGIC STUDIES**

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

Opening pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was an additional 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\_\_\_\_\_\_\_\_\_\_\_

Opening pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Were any of the following pathogens tested for? If so, what was the result? (including specimen and type of test)
2. *Campylobacter jejuni* □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. *Mycoplasma pneumoniae* □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. *Haemophilus influenzae* □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. *Salmonella spp.* □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Cytomegalovirus (CMV) □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Epstein-Barr virus (EBV) □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Varicella-zoster virus (VZV) □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Human immunodeficiency virus (HIV) □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Herpes simplex virus (HSV) □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Enterovirus / Rhinovirus □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Arboviruses □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. Cryptococcus □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. Toxoplasmosis □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
15. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
17. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
18. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
19. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
20. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
21. 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

**ANTECEDENT ILLNESS**

1. **a.)** In the 2 months prior to neuro onset date, did the individual experience an acute illness?

□ Yes □No □ Unknown

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

1. **b.)** 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

**c.)** 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 \_\_\_

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

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

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

**g.)** 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
2. Is there a test result available for chikungunya from this medical visit? □ Yes □ No □ Unknown
3. Is there a test result available for Zika from this medical visit? □ Yes □ No □ Unknown
4. What medical conditions are listed in the admission history and physical (H&P)?

**PAST MEDICAL, SOCIAL, AND FAMILY HISTORY**

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

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

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

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

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

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

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

1. Did the patient receive a vaccine in the previous 6 months? □ Yes □ No □ Unknown

If yes, vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of vaccination: \_\_ \_\_ /\_\_ \_\_ /\_\_\_\_\_\_\_\_
 MM DD YYYY

**OTHER NEUROLOGIC CONDITIONS**

1. What other neurologic conditions were identified by the provider?

 □ ADEM □ CIDP □ Encephalitis □ Encephalomyelitis □ Facial paralysis

 □ Meningoencephalitis □ Myasthenia gravis □ Myelitis □ Myelopathy

 □ Multiple sclerosis (MS) □ Neuropathy □ Optic neuritis □ Paresthesia

 □ Papilledema □ Transverse myelitis □ Sensory motor peripheral neuropathy

 □ Stroke □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Additional signs or symptoms not already noted:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| □ | Agitation | □ | Altered lacrimal gland secretion | □ | Altered mental status | □ | Altered salivary gland secretion |
| □ | Aphasia | □ | Confusion | □ | Drooping corner of mouth | □ | Eye pain |
| □ | Eyebrow sagging | □ | Fatigable chewing | □ | Fever | □ | Headache |
| □ | Inability to close eye | □ | Irritability | □ | Lethargy | □ | Lower extremity dysthesesia |
| □ | Loss of taste anterior 2/3 of tongue | □ | Memory loss | □ | Nausea | □ | Nasolabial fold disappearance |
| □ | Nuchal rigidity | □ | Nystagmus | □ | Oculomotor deficits | □ | Personality changes |
| □ | Ptosis | □ | Seizures | □ | Sensory deficits: | □ | Somnolence |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ | Transient visual obscuration | □ | Tremors | □ | Upper extremity dysthesesia | □ | Urinary retention |
| □ | Vision loss | □ | Vomiting | □ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |