

## Appendix 1. Chart Abstraction Form

Patient Name: \_\_\_\_\_

CDC ID#: \_\_\_\_\_

Hospital #1: \_\_\_\_\_

MRN#: \_\_\_\_\_

Hospital #2 (if transferred): \_\_\_\_\_

MRN#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Alt Telephone number: \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average XX 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-XXXX)

Name of person completing form: _____			
<b>Demographic Information</b>			
Age: _____	DOB ____ / ____ / ____		
Sex:	Male	Female	
What is your race? (Check all that apply.):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	
Are you Hispanic or Latino?:	Yes	No	
Work (describe):			
<b>Timeline and Outcome</b>			
Date of prodrome (includes GI symptom) onset: ____/____/____	No prodrome		
Date of neuro illness onset: ____/____/____			
Date of first hospital admission: ____/____/____			
Initial or admitting diagnosis:			
Outcome of illness:	Died (Date (dd/mmm/yyyy): _____)		
	Discharged to chronic care or rehabilitation facility		(Date: _____)
	Discharged to home (Date: _____)		
	Still hospitalized		
<b>Prodrome Illness Symptoms</b>			
<u>Diarrhea</u>	Yes No Unk	<u>Vomiting</u>	Yes No Unk
<u>Fever</u>	Yes No Unk	<u>Cough</u>	Yes No Unk
<u>Sore Throat</u>	Yes No Unk	<u>Joint pains/aches</u>	Yes No Unk
		<u>Bloody stool</u>	Yes No Unk
		<u>Headache</u>	Yes No Unk
		<u>Rash</u>	Yes No Unk
		<u>Abdominal Pain</u>	Yes No Unk
		<u>Other</u>	_____
Duration of prodromal symptoms: _____ days			
Location of patient in 7 days before prodromal symptoms:			
<b>Past Medical and Neurological History</b>			
Past Medical and Neurological History (include EtOH, tobacco, drug use):			
<b>Exposure History</b>			
Travel History (include all places visited in prior 30 days—include dates of travel):			
Describe any agricultural or pesticide exposure in past 6 weeks:			
Any upper respiratory infection in the last 6 weeks?      Yes    No			
Unk		What date of onset?: ____/____/____	

Any gastrointestinal infection in the last 6 weeks? Unk	Yes	No	What date of onset?: ___/___/_____
Any vaccinations received in the last 6 weeks? Unk	Yes	No	If yes, date of receipt: ___/___/_____ If yes, vaccine(s)_administered_____
Ill household contacts in the past 6 weeks? Unk	Yes	No	Nature of illness: _____

**Toxic/Chemical Exposures**

1. Did patient recall taking any herbal or folk remedies during 2 weeks prior to illness <b>If YES,</b> Remedy 1: _____ Remedy 2: _____	Yes	No	Unknown
3. Did patient recall eating any wild picked plants (like. buckthorn or Karwinskia Humboldt pictured below) during 2 weeks prior to illness onset? If YES, Plant 1: _____ Plant 2: _____	Yes	No	Unknown

**Neuro Symptoms**

Initial neurological signs and symptoms (describe): \_\_\_\_\_

Onset of weakness within first week of neuro illness?	Yes	No	Unknown
Concurrent symptoms:	Fever	Headache	Meningismus (nuchal rigidity, photo/phonophobia)
Altered mental status	Nausea/vomiting	Muscle pain/myalgia	Other
Specify if other: _____			

Distribution of weakness at first onset (e.g. first noted weakness) Check all that apply:	Symmetric	Asymmetric	Unknown
	Right UE Prox      Dist	Left UE Prox      Dist	Right LE Prox      Dist
	Left LE Prox      Dist	Right UE Prox      Dist	Left UE Prox      Dist
Neck Flexors/Extens.	Respiratory muscles	Quadruplegia/whole body paralysis	Facial muscles
Describe weakness distribution: _____			

Nature of weakness onset:	Ascending	Descending	Acute/whole limb	Unknown
Approximate time interval to maximal weakness: _____				

Distribution of weakness at <b>maximal</b> weakness Check all that apply:	Symmetric	Asymmetric	Unknown	
	Right UE Prox      Dist	Left UE Prox      Dist	Right LE Prox      Dist	
	Left LE Prox      Dist	Right UE Prox      Dist	Left UE Prox      Dist	
Neck Flexors/Extens.	Respiratory muscles	Quadruplegia/whole body paralysis	Facial muscles	
Describe weakness distribution at maximum: _____				
Approximate date of maximal weakness: ___/___/_____				

<p><u>Reflexes</u> in affected body parts at time of maximal weakness:</p> <p>Hyperreflexic/spastic                      Reflexes not tested</p>	<p>Areflexic</p> <p>Unknown</p>	<p>Hyporeflexic</p>	<p>Reflexes normal</p>
<p><u>Tone</u> in affected body parts at time of maximal weakness:</p> <p>Hypertonic/spastic                      Tone not tested</p>	<p>Flaccid</p> <p>Unknown</p>	<p>Hypotonic</p>	<p>Tone normal</p>
<p><u>Sensory</u> abnormalities present?</p> <p>    Date of sensory symptom onset: ____/____/____</p> <p>    Description of sensory abnormalities: _____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p><u>Pain</u> present?</p> <p>    Date of pain onset: ____/____/____</p> <p>    Description/location of pain: _____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Prominent dyspnea/shortness of breath present?</p> <p>    Approximate date of dyspnea onset: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Patient ever intubated?                      Yes          No          Unknown</p> <p>    Date of extubation: _____</p>	<p>If yes, date of intubation: _____</p> <p>    Tracheostomy required?                      Yes          No          Unknown</p>		
<p>Bowel/Bladder involvement present?</p> <p>    Description of bowel/bladder involvement: _____</p> <p>    Date of bowel/bladder involvement: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Dysarthria and/or dysphagia present?</p> <p>    Date of dysarthria/dysphagia: ____/____/____</p> <p>    Description of dysarthria/dysphagia: _____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>15. Any other cranial nerve abnormalities present?</p> <p>    If yes, specify cranial nerve abnormality, as specifically as possible:</p> <p>    Date of onset of CN abnormality: ____/____/____                      Date of resolution of CN abnormality: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Ataxia present?</p> <p>    If yes, date ataxia noted / recorded: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Does the Neurology Consult Note attribute neurologic symptoms to a definitive diagnosis other than Guillain-Barre Syndrome?                      Yes      No</p> <p>If yes, what was the rendered diagnosis: _____</p>			
<p><b>Hospital Course</b></p>			
<p>Please list nosocomial complications (if any):</p>          			

**Laboratory Testing**

Serum Potassium \_\_\_\_\_ on admission \_\_\_\_\_ most abnormal  
 Serum Calcium \_\_\_\_\_ on admission \_\_\_\_\_ most abnormal

**Cerebrospinal fluid**

Did the patient have any lumbar punctures (LP) performed within 30 days of onset of weakness? Yes No Unknown

Date CSF 1: \_\_\_/\_\_\_/\_\_\_ WBC \_\_\_/mm<sup>3</sup> RBC \_\_\_/mm<sup>3</sup> Protein \_\_\_ mg/dL Glucose \_\_\_ mg/dL

WBC differential: Neutrophils \_\_\_% Lymphocytes \_\_\_% Monocytes \_\_\_% Eosinophils \_\_\_%

Date CSF 2: \_\_\_/\_\_\_/\_\_\_ WBC \_\_\_/mm<sup>3</sup> RBC \_\_\_/mm<sup>3</sup> Protein \_\_\_ mg/dL Glucose \_\_\_ mg/dL

WBC differential: Neutrophils \_\_\_% Lymphocytes \_\_\_% Monocytes \_\_\_% Eosinophils \_\_\_%

12. CSF Gram's Stain: Record result: \_\_\_\_\_

13. CSF VRDL: \_\_\_\_\_ 14. CSF Cryptococcal Antigen: \_\_\_\_\_

18. CSF Oligoclonal Bands: \_\_\_\_\_ 19. IgG Index: \_\_\_\_\_

20. IgG Synthesis Rate: \_\_\_\_\_ 21. Myelin Basic Protein: \_\_\_\_\_

**Neurodiagnostics: Please indicate whether the following tests were performed. Record all results on accompanying worksheet.**

- |  |                                      |
|--|--------------------------------------|
| 1. Head computed tomography                  | 2. Spinal computed tomography        |
| 3. Brain magnetic resonance imaging          | 4. Spinal magnetic resonance imaging |
| 5. Electromyography/nerve conduction studies | 6. Pulmonary fluoroscopic studies    |

**Please indicate whether any of the following treatments or procedures were rendered during the course of illness:**

- |  |                                    |                           |
|--|------------------------------------|---------------------------|
| 1. Intravenous Immune Globulin (IVIG)          | Date started: ___/___/___          | Date stopped: ___/___/___ |
| 2. Plasmapheresis/plasma exchange              | Date started: ___/___/___          | Date stopped: ___/___/___ |
| 3. Alpha-interferon                            | Date started: ___/___/___          | Date stopped: ___/___/___ |
| 4. Corticosteroids                             | Date started: ___/___/___          | Date stopped: ___/___/___ |
| If yes, dosage used: _____                     |                                    |                           |
| 5. Other immunomodulating agent (Imuran, etc.) | Date started: ___/___/___          | Date stopped: ___/___/___ |
| If yes, specify: _____                         |                                    |                           |
| 7. Muscle biopsy                               | If yes, date obtained: ___/___/___ |                           |
| If yes, specify site of biopsy: _____          |                                    |                           |
| If yes, narrative of result: _____             |                                    |                           |
| _____  |                                    |                           |

**Lab results: Culture results**

If any bacterial, viral or fungal culture results were obtained, please note the following results

Specimen type*	Date	Culture type (Check one)			Result (Check one)		If positive:		
		Bacterial	Viral	Fungal	No growth	Positive	Organism 1	Organism 2	Organism 3

\*Specimen type: Blood, bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), nasopharyngeal swab/aspirate, pericardial fluid, peritoneal fluid, pleural fluid, sputum, synovial fluid, tissue (specify site), throat/oropharyngeal swab, stool or urine

**Diagnostic Tests for Other Infectious Diseases (include Antibody tests/serology, antigen detection, PCR and special stains)**

Specimen type*	Date	Test performed	Results	Interpretation	Laboratory





Please attach results of all neurodiagnostics (include detailed EMG results if available):

FINAL BRIGHTON CASE DEFINITION CLASSIFICATION: (See Appendix

Guillain-Barre Syndrome

Level 1

Level 2

Level 3

Level 4

Level 5

Fisher Syndrome:

Level 1

Level 2

Level 3

Level 4

Level 5

**APPENDIX I: BRIGHTON CASE DEFINITION CRITERIA****Guillain-Barré Syndrome**Level 1 (requires ALL criteria)

1. Bilateral **AND** flaccid weakness of the limbs
2. Decreased or absent deep tendon reflexes in weak limbs
3. Monophasic illness pattern **AND** interval between onset and nadir of illness between 12 hours and 28 days **AND** subsequent clinical plateau
4. Electrophysiologic findings consistent with GBS
5. Cytoalbuminologic dissociation (i.e., elevation of CSF protein level above laboratory normal value **AND** CSF total white cell count <50 cells / mm<sup>3</sup>)
6. Absence of an identified alternative diagnosis for weakness

Level 2

1. Criteria 1, 2, and 3 for Level 1 fulfilled  
**AND**
2. CSF total white cell count <50 cells/mm<sup>3</sup> (with or without CSF protein elevation above laboratory normal value)  
**OR**  
If CSF not collected or results not available, electrophysiologic studies consistent with GBS
3. Absence of identified alternative diagnosis for weakness

Level 3

1. Criteria 1, 2, and 3 for Level 1 fulfilled
2. Absence of identified alternative diagnosis for weakness

Level 4

1. Reported event of GBS, with insufficient evidence to meet case definition

Level 5

1. Not a case of GBS

**Fisher Syndrome**Level 1 (Requires ALL Criteria)

1. Bilateral ophthalmoparesis **AND** bilateral reduced or absent tendon reflexes, **AND** ataxia
2. Absence of limb weakness

3. Monophasic illness pattern **AND** interval between onset and nadir of weakness between 12 hours and 28 days **AND** subsequent clinical plateau
4. Cytoalbuminologic dissociation (i.e., elevation of cerebrospinal protein above the laboratory normal **AND** total CSF white cell count <50 cells/mm<sup>3</sup>)
5. Nerve conduction studies are normal, **OR** indicate involvement of sensory nerves only
6. No alteration in consciousness or corticospinal tract signs
7. Absence of an identified alternative diagnosis

#### Level 2

1. Criteria 1, 2, and 3 for Level 1 fulfilled  
**AND**
2. Cerebrospinal fluid (CSF) with a total white cell count <50 cells/mm<sup>3</sup> (with or without CSF protein elevation above laboratory normal value)  
**OR**  
Nerve conduction studies are normal, **OR** indicate involvement of sensory nerves only
3. No alteration in consciousness or corticospinal tract signs
4. Absence of an identified alternative diagnosis

#### Level 3

1. Criteria 1, 2, 3, 6, and 7 for Level 1 fulfilled

#### Levels 4 and 5 as for GBS