**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***](mailto:limbweakness@cdc.gov) ***if sending to CDC-------------------------------------------------------------***

**Acute Flaccid Myelitis: Patient Summary Form**

Form Approved

OMB No. 0920-0009

Exp Date: 06/30/2019

***Please send the following information along with the patient summary form (check information included):***

🞎 *History and physical (H&P)* 🞎 *MRI report* 🞎 *MRI images* 🞎 *Neurology consult notes* 🞎 *EMG report (if done)*

🞎 *Infectious disease consult notes (if available)* 🞎 *Vaccination record* 🞎 *Diagnostic laboratory reports*

**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**. Weakness? [*indicate yes(y), no (n), unknown (u)* ***for each limb***] | | Y N U | | | Y N U | | Y N U | Y N U |
| **15a**. Tone in **affected** limb(s) [*flaccid, spastic, normal* ***for each limb***] | | 🞎 flaccid  🞎 spastic  🞎 normal  🞎 unknown | | | 🞎 flaccid  🞎 spastic  🞎 normal  🞎 unknown | | 🞎 flaccid  🞎 spastic  🞎 normal  🞎 unknown | 🞎 flaccid  🞎 spastic  🞎 normal  🞎 unknown |
|  | Yes | | No | Unk | |  | | |
| **16.** Was patient admitted to ICU? |  | |  |  | | **17.** If yes, admit date: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| In the 4-weeks **BEFORE onset** of **limb weakness**, did patient: | Yes | No | Unk |  |
| **18**. Have a respiratory illness? |  |  |  | **19**. If yes, onset date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| **20**. Have a gastrointestinal illness (e.g., diarrhea or vomiting)? |  |  |  | **21**. If yes, onset date \_\_ \_\_/\_\_ \_\_/ \_\_ \_\_ \_\_ \_\_ |
| **22**. Have a fever, measured by parent or provider ≥38.0°C/100.4°F? |  |  |  | **23**. If yes, onset date \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| **24.** Travel outside the US? |  |  |  | **25.** If yes, list country: |
| **26**. At onset of limb weakness, does patient have any underlying illnesses? |  |  |  | **27.** If yes, list: |

**Other patient information:**

**28.** Was MRI of spinal cord performed? 🞎 yes 🞎 no 🞎 unknown **29.** If yes, date of spine MRI: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

**30.** Was MRI of brain performed? 🞎 yes 🞎 no 🞎 unknown **31.** If yes, date of brain MRI: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

**CSF examination: 32**. Was a lumbar puncture performed? 🞎 yes 🞎 no 🞎 unknown

If yes, complete 32 (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 |
| **32a.** **CSF** from LP1 |  |  |  |  |  |  |  |  |  |
| **32b.** **CSF** from LP2 |  |  |  |  |  |  |  |  |  |

**Acute Flaccid Myelitis Outcome – 60-day follow-up (*completed at least 60 days after onset of limb weakness*)**

**33**. Date of 60-day follow-up: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ *(mm/dd/yyyy)*

**34.** Sites of Paralysis:🞎 Spinal 🞎 Bulbar 🞎 Spino-bulbar **35.** Specific sites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**36.** 60-day residual: 🞎 None 🞎 Minor (any minor involvement) 🞎 Significant (≤2 extremities, major involvement)

🞎 Severe (≥3 extremities and respiratory involvement) 🞎 Death 🞎 Unknown

**37.** Date of death: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ *(mm/dd/yyyy)*

**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

● 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

● CSF showing pleocytosis (white blood cell count >5 cells/mm3).

**Acute Flaccid Myelitis specimen collection information**

(<https://www.cdc.gov/acute-flaccid-myelitis/hcp/instructions.html>)

**Acute Flaccid Myelitis job aid**

(<https://www.cdc.gov/acute-flaccid-myelitis/downloads/job-aid-for-clinicians.pdf>)