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 if sending to CDC***----------

Acute Flaccid Myelitis: Patient Summary Form

Form Approved
OMB No. 0920-0009
Exp Date: XX/XX/XXXX

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 ☐Native Hawaiian or Other Pacific Islander ☐White *(check all that apply)*

8. Ethnicity: ☐Hispanic or Latino ☐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/mm^3	% neutrophils	% lymphocytes	% monocytes	% eosinophils	RBC/mm^3	Glucose mg/dl	Protein mg/dl
32a. CSF from LP1									
32b. CSF from LP2									

Acute Flaccid Myelitis Outcome – follow-up of confirmed and probable AFM cases (*completed at 60 days, 6 months and 12 months after onset of limb weakness*)

33. Date of follow-up: __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*

36. Impairment: ☐ 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)*

38**. Physical condition** (includes cardiovascular, gastrointestinal, urologic, endocrine as well as neurologic disorders):

i. Medical problems sufficiently stable that medical or nursing monitoring is not required more often than 3-month intervals
ii. Medical or nurse monitoring is needed more often than 3-month intervals but not each week.
iii. Medical problems are sufficiently unstable as to require medical and/or nursing attention at least weekly.
iv. Medical problems require intensive medical and/or nursing attention at least daily (excluding personal care assistance)

39. **Upper limb functions**: Self-care activities (drink/feed, dress upper/lower, brace/prosthesis, groom, wash, perineal care) dependent mainly upon upper limb function:

i. Age-appropriate independence in self-care without impairment of upper limbs
ii. Age-appropriate independence in self-care with some impairment of upper limbs
iii. Dependent upon assistance in self-care with or without impairment of upper limbs.
iv. Dependent totally in self-care with marked impairment of upper limbs.

40. **Lower limb functions**: Mobility (walk, stairs, wheelchair, transfer chair/toilet/tub or shower) dependent mainly upon lower limb function:

i. Independent in mobility without impairment of lower limbs
ii. Independent of mobility with some impairment of lower limbs, such as needing ambulatory aids, a brace or prosthesis
iii. Dependent upon assistance or supervision in mobility with or without impairment of lower limbs.
iv. Dependant totally in mobility with marked impairment of lower limbs.

41. **Sensory components**: Relating to communication (speech and hearing) and vision:

i. Age-appropriate independence in communication and vision without impairment
ii. Age-appropriate independence in communication and vision with some impairment such as mild dysarthria, mild aphasia or need for eyeglasses or hearing aid.
iii. Dependent upon assistance, an interpreter, or supervision in communication or vision
iv. Dependent totally in communication or vision

42. **Excretory functions** (bladder and bowel control, age-appropriate):

i. Complete voluntary control of bladder and bowel sphincters
ii. Control of sphincters allows normal social activities despite urgency or need for catheter, appliance, suppositories, etc.
iii. Dependent upon assistance in sphincter management
iv. Frequent wetting or soiling from bowel or bladder incontinence

43. **Support factors**:

i. Able to fulfil usual age-appropriate roles and perform customary tasks
ii. Must make some modifications in usual age-appropriate roles and performance of customary tasks
iii. Dependent upon assistance, supervision, and encouragement from an adult due to any of the above considerations
iv. Dependent upon long-term institutional care (chronic hospitalization, residential rehabilitation, etc. Excluding time-limited hospitalization for specific evaluation or treatment)

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/mm^3)

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/mm^3).

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)