

**CDC REYE SYNDROME CASE INVESTIGATION REPORT**

ID No. (1-4)

Please write in where necessary, and check boxes where applicable (disregard numbers in parentheses).

1. Name of Reporting Individual		2. First 3 letters of Patient's last name (5-7)			
Address Street		3. State	4. County	FOR CDC USE ONLY (8-9) (10-12)	
City State Zip Code					
Telephone No. (Area Code)		5. Age in years: (if under 3 yrs old) months (13-14) (15-16)		6. Patient's Sex: (17) <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female	
Name of Hospital With Which Affiliated		7. Patient's Race: (18) <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. Asian <input type="checkbox"/> 4. American Indian or Alaskan Native <input type="checkbox"/> 5. Hawaiian/Pacific Islander		8. Patient's Ethnicity: (19) <input type="checkbox"/> 1. Hispanic or Latino <input type="checkbox"/> 2. Not Hispanic or Latino <input type="checkbox"/> 3. Not Specified	
Name of City in Which Hospital is Located					

9. Was patient hospitalized? (20)  1 Yes  0 No  9 Unknown

IF PATIENT HOSPITALIZED, REPORT THE FOLLOWING FOR EACH HOSPITAL IN WHICH PATIENT WAS HOSPITALIZED:

Name and City of 1st hospital			Name and City of 2nd hospital		
Date of 1st hospitalization	Mo. Day Yr.		Date of 2nd hospitalization	Mo. Day Yr.	
	(21-26)			(33-38)	
Date of discharge from 1st hospital, or death	Mo. Day Yr.		Date of discharge from 2nd hospital, or death	Mo. Day Yr.	
	(27-32)			(39-44)	

10. Date of onset of Reye Syndrome (onset of severe vomiting or mental status change, whichever appeared first). Mo. Day Yr. (45-50)

11. During the 3 weeks before onset of Reye Syndrome was there an antecedent illness? (51)  1 Yes  0 No  9 Unknown

If yes, date of onset of antecedent illness Mo. Day Yr. (52-57)

12. If there was an antecedent illness, was there:

	Yes	No	Unknown	
Diarrhea as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(58)
Respiratory symptoms as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(59)
Fever as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(60)
Chickenpox as the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(61)
Other rash as part of the antecedent illness?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	(62)

13. A. Was there vomiting at any time? (63)  1 Yes  0 No  9 Unknown

B. If there was vomiting at any time, was the vomiting? (check only one) (64)

Part of the antecedent illness  1 or part of both antecedent and Reye Syndrome  3

Part of the Reye Syndrome  2 Unknown  9

14. A. Check the appropriate box to indicate the best description of the patient's condition at admission to the hospital where the major part of therapy (or at diagnosis, if not hospitalized) was performed.

B. Check the best description of the patient's condition during the most severe phase of illness.

	A. Patient's Condition at Admission (Check Only One) (65)	B. Patient's Condition During Most Severe Phase of Illness (Check Only One) (66)
Alert wakefulness	0 <input type="checkbox"/>	<input type="checkbox"/>
Difficult to arouse, lethargic, sleepy	1 <input type="checkbox"/>	<input type="checkbox"/>
Delirious, combative, purposeful or semi-purposeful motor responses	2 <input type="checkbox"/>	<input type="checkbox"/>
Unarousable, predominantly flexor motor responses, decorticate	3 <input type="checkbox"/>	<input type="checkbox"/>
Unarousable, predominantly extensor motor responses, decerebrate	4 <input type="checkbox"/>	<input type="checkbox"/>
Unarousable, flaccid paralysis, areflexia pupils unresponsive	5 <input type="checkbox"/>	<input type="checkbox"/>
Curarized or equivalent, therefore could not classify	6 <input type="checkbox"/>	<input type="checkbox"/>
Condition unknown	9 <input type="checkbox"/>	<input type="checkbox"/>

15. Was patient vaccinated during month preceding onset of Reye Syndrome? (67)  1 Yes  0 No  9 Unknown

IF YES, SPECIFY VACCINE AND DATE RECEIVED

Vaccine	Date Received
	Mo. Day Yr.
	(68-73)
	(74-79)
	(80-85)

16. Did the patient ever have a previous case of physician-diagnosed Reye Syndrome? (86)  1 Yes  0 No  9 Unknown

17. Has Reye Syndrome ever been diagnosed in a sibling or blood relative? (87)  1 Yes  0 No  9 Unknown

Public reporting burden of this collection of information is estimated to average 20 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 (0920-0009).

**LABORATORY DATA**

18. Did the patient have a recent viral or bacterial infection (associated with Reye Syndrome) documented by culture, serology or other laboratory test?

				IF YES, HOW WAS AGENT IDENTIFIED			
	Yes	No	Unknown	Culture	Serology	Other	Unknown
Flu A	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9 (88)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9 (89)
Flu B	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9 (90)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9 (91)
Other (specify)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9 (92)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9 (93)

19. Was there a three-fold or greater elevation in the normal laboratory value of either the serum SGOT, SGPT or NH<sub>3</sub>? (94)  1 Yes  0 No  9 Unknown

20. What were the patient's highest lab values for the following:

SGOT     Units (95-98)      SGPT     Units (99-102)      NH<sub>3</sub>     μg/100ml (103-106)

21. What was the lowest serum glucose value?     mg% (107-110)

22. What were the patient's highest lab values for the following:

CPK     Units (111-114)      BLANK     (115-116)

23. Was patient's cerebrospinal (CSF) cell count normal? (117)  1 Yes  0 No  3 Not done

Enter the following in spaces provided:

TOTAL WBC     mm<sup>3</sup> (118-121)      RBC     mm<sup>3</sup> (122-125)      %LYMPH   (126-127)      %POLY   (128-129)      PROT   mg% (130-131)      GLUCOSE    mg% (132-134)

24. Was blood for a salicylate level obtained within 48 hours of admission to the hospital? (135)  1 Yes  0 No  9 Unknown

If YES, was salicylate detectable? (136)  1 Yes  0 No  9 Unknown      BLANK     (139)-(162)

If YES, how many mg %?   (137-138)

25. What was outcome of this illness? Select the most appropriate answer. (163)

- 1. Prognosis unclear at present
- 2. Patient recovered
- 3. Suffered mild neurological residual
- 4. Suffered severe neurological residual
- 5. Patient died
- 6. Outcome unknown

26. Is there biopsy confirmation of the diagnosis? (check only one) (164)

- 1 Yes       3 Biopsy not done
- 0 No       9 Unknown

27. IF APPLICABLE, is there autopsy confirmation of the diagnosis? (165)

- 1 Yes, autopsy confirmed diagnosis of Reye Syndrome.       3 Autopsy not done
- 0 No, autopsy was done but did not confirm diagnosis of Reye Syndrome       9 Unknown

28. ENTER DATA REPORT TAKEN

Mo.   Day   Yr.   BILIRUBIN (total)     mg/100ml (172-174)

29. Is the patient one of identical twins? (175)  1 Yes  0 No  9 Unknown

30. Was blood for an acetaminophen level obtained within 48 hours of admission to the hospital? (176)

1 Yes  0 No  9 Unknown

If YES, was acetaminophen detectable? (177)

1 Yes  0 No  9 Unknown

If YES, how many μg/ml   (178-179)

**QUESTION 30 (A, B, C & D) OPTIONAL**

31. A. Did the patient take any medications (nonprescription or prescribed) during the 3 weeks prior to the onset of Reye Syndrome (defined as vomiting or mental status changes)? (180)

1 Yes  0 No  9 Unknown

B. Please list all of these medications below (include brand names if possible): (181-186)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

C. How did you obtain this medication history?

1. Chart review  (187)
2. Interviewed patient's physician  (188)
3. Interviewed patient's parent  (189)
4. Other (specify) \_\_\_\_\_  (190)

D. If obtained only by chart review, which did the medication history specifically indicate? (check all that apply)

1. Patient took acetaminophen during the three weeks  (191)
2. Patient did not take acetaminophen during the three weeks  (192)
3. No information regarding acetaminophen ingestion  (193)
4. Patient took salicylate during the three weeks  (194)
5. Patient did not take salicylate during the three weeks  (195)
6. No information regarding salicylate ingestion  (196)

32. A. Does the patient have a disease which requires the patient to take salicylate-containing medications regularly?

(197)  1 Yes  0 No  9 Unknown

B. If YES, what is the disease?

1. Juvenile Rheumatoid Arthritis
2. Other (specify): \_\_\_\_\_  (198)

RETURN TO: Centers for Disease Control  
ATTN: Reye Syndrome Unit  
Building 6, Room 125  
Atlanta, Georgia 30333

PLEASE CHECK OVER ALL ANSWERS TO MAKE SURE THEY CAN BE READ AND PROCESSED APPROPRIATELY FOR DATA COLLECTION.