

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 AFMInfo@cdc.gov if sending to CDC-----

Acute Flaccid Myelitis: Patient Summary Form

Form Approved
 OMB No. 0920-0009
 Exp Date: 08/31/2022

Please send the following information along with the patient summary form: MRI report MRI images Neurology consult note

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	
15a. Tone in affected limb(s) [flaccid, spastic, normal for each limb]	<input type="checkbox"/> flaccid		<input type="checkbox"/> flaccid		<input type="checkbox"/> flaccid		<input type="checkbox"/> flaccid		<input type="checkbox"/> flaccid	
	<input type="checkbox"/> spastic		<input type="checkbox"/> spastic		<input type="checkbox"/> spastic		<input type="checkbox"/> spastic		<input type="checkbox"/> spastic	
	<input type="checkbox"/> normal		<input type="checkbox"/> normal		<input type="checkbox"/> normal		<input type="checkbox"/> normal		<input type="checkbox"/> normal	
	<input type="checkbox"/> unknown		<input type="checkbox"/> unknown		<input type="checkbox"/> unknown		<input type="checkbox"/> unknown		<input type="checkbox"/> 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. Have pain in neck or back?				25. If yes, onset date ___/___/___						
26. At onset of limb weakness, does patient have any underlying illnesses?				27. If yes, list:						

Travel history:	
28. Did the patient travel outside of the US in the 30 days before the onset of limb weakness?	" yes " no " unknown
28a. If yes, list country/countries	

Polio vaccination history:	
29. Has the patient received polio vaccine?	" yes " no " unknown
29a. How many doses of inactivated polio vaccine (IPV) are documented to have been received by the patient before the onset of limb weakness?	___ doses " unknown
29b. How many doses of oral polio vaccine (OPV) are documented to have been received by the patient before the onset of limb weakness?	___ doses " unknown
29c. How many doses of unknown type of polio vaccine are documented to have been received by the patient before the onset of limb weakness?	___ doses " unknown

Magnetic Resonance Imaging:

Public reporting burden of this collection of information is estimated to average 12 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.

30. Was MRI of spinal cord performed? yes no unknown 31. If yes, date of spine MRI: ___/___/_____

32. Did the spinal MRI show a lesion in at least some spinal cord gray matter? yes no unknown

33. Was MRI of brain performed? yes no unknown 34. If yes, date of brain MRI: ___/___/_____

CSF examination: 35. Was a lumbar puncture performed? yes no unknown

If yes, complete 35 (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
35a. CSF from LP1									
35b. CSF from LP2									

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.

At time of 60 day follow-up please collect and send the following information: for confirmed and probable cases

- Discharge summary History and physical (H&P) Neurology consult notes EMG report (if done)
 Infectious disease consult notes (if available) Vaccine registry record Diagnostic laboratory reports
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Acute Flaccid Myelitis Outcome – complete follow-up for all reported persons under investigation (PUI) at 60 days after onset of limb weakness.

36. Date of follow-up: ___/___/____ (mm/dd/yyyy)

37. Impairment: None Minor (any minor involvement) Significant (≤ 2 extremities, major involvement)
 Severe (≥ 3 extremities and respiratory involvement) Death Unknown

37a. 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

(https://cdn.ymaws.com/www.cste.org/resource/resmgr/ps/ps2021/21-ID-02_AFM.pdf)

Clinical Criteria

An illness with onset of acute flaccid* limb weakness **AND**

Absence of a clear alternative diagnosis attributable to a nationally notifiable condition.

* Low muscle tone, limp, hanging loosely, not spastic or contracted.

Confirmatory laboratory/imaging evidence:

MRI showing spinal cord lesion with predominant gray matter involvement* and spanning one or more vertebral segments, **AND**
Excluding persons with gray matter lesions in the spinal cord resulting from physician diagnosed malignancy, vascular disease, or anatomic abnormalities.

Presumptive laboratory/imaging evidence:

MRI showing spinal cord lesion where gray matter involvement* is present but predominance cannot be determined, **AND**
Excluding persons with gray matter lesions in the spinal cord resulting from physician diagnosed malignancy, vascular disease, or anatomic abnormalities.

Supportive laboratory/imaging evidence:

MRI showing a spinal cord lesion in at least some gray matter* and spanning one or more vertebral segments, **AND**
Excluding persons with gray matter lesions in the spinal cord resulting from physician diagnosed malignancy, vascular disease, or anatomic abnormalities.

* Spinal cord lesions may not be present on initial MRI; a negative or normal MRI performed within the first 72 hours after onset of limb weakness does not rule out AFM. Terms in the spinal cord MRI report such as "affecting mostly gray matter," "affecting the anterior horn or anterior horn cells," "affecting the central cord," "anterior myelitis," or "poliomyelitis" would all be consistent with this terminology.

Other classification criteria

Autopsy findings that include histopathologic evidence of inflammation largely involving the anterior horn of the spinal cord spanning one or more vertebral segments.

Vital Records Criteria

Any person whose death certificate lists acute flaccid myelitis as a cause of death or a condition contributing to death.

Case Classification

Confirmed:

Meets clinical criteria with confirmatory laboratory/imaging evidence, **OR**

Meets other classification criteria.

Probable:

Meets clinical criteria with presumptive laboratory/imaging evidence.

Suspect:

Meets clinical criteria with supportive laboratory/imaging evidence, **AND**

Available information is insufficient to classify case as probable or confirmed.

Acute Flaccid Myelitis specimen collection information

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

Acute Flaccid Myelitis job aid

(<https://www.cdc.gov/acute-flaccid-myelitis/downloads/job-aid-for-clinicians-508.pdf>)