

## 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): _____)<br>Discharged to chronic care or rehabilitation facility (Date: _____)<br>Discharged to home (Date: _____)<br>Still hospitalized |            |                                         |            |                           |            |
| <b>Prodrome Illness Symptoms</b>                                                            |            |                                                                                                                                                                   |            |                                         |            |                           |            |
| <u>Diarrhea</u>                                                                             | Yes No Unk | <u>Vomiting</u>                                                                                                                                                   | Yes No Unk | <u>Bloody stool</u>                     | Yes No Unk | <u>Rash</u>               | Yes No Unk |
| <u>Fever</u>                                                                                | Yes No Unk | <u>Cough</u>                                                                                                                                                      | Yes No Unk | <u>Headache</u>                         | Yes No Unk | <u>Abdominal Pain</u>     | Yes No Unk |
| <u>Sore Throat</u>                                                                          | Yes No Unk | <u>Joint pains/aches</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                                                                                                                                                            |            | What date of onset?: ____ / ____ / ____ |            |                           |            |
| Unk                                                                                         |            |                                                                                                                                                                   |            |                                         |            |                           |            |

## Case Data Collection Worksheet

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------|---------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------|--|-----------|------------|---------|-----------------------|----------|---------|----------|---------|----------------|----------------|----------------|----------------|----------------------|---------------------|-----------------------------------|--|----------------|--------------------------------------------------|--|--|--|--|------------------------------------------------------|--|--|--|--|
| Any gastrointestinal infection in the last 6 weeks?<br>Unk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Yes                 | No                                | What date of onset?: ____/____/____                                             |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Any vaccinations received in the last 6 weeks?<br>Unk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Yes                 | No                                | If yes, date of receipt: ____/____/____<br>If yes, vaccine(s)_administered_____ |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Ill household contacts in the past 6 weeks?<br>Unk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Yes                 | No                                | Nature of illness: _____                                                        |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| <b>Toxic/Chemical Exposures</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| 1. Did patient recall taking any herbal or folk remedies during 2 weeks prior to illness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes                 | No                                | Unknown                                                                         |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| If YES, Remedy 1: _____<br>Remedy 2: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| 3. Did patient recall eating any wild picked plants (like. buckthorn or Karwinskia Humboldt pictured below) during 2 weeks prior to illness onset?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Yes                 | No                                | Unknown                                                                         |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| If YES, Plant 1: _____<br>Plant 2: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| <b>Neuro Symptoms</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| 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: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| <table border="0" style="width: 100%;"> <tr> <td colspan="2">Distribution of weakness at first onset (e.g. first noted weakness)</td> <td>Symmetric</td> <td>Asymmetric</td> <td>Unknown</td> </tr> <tr> <td rowspan="2">Check all that apply:</td> <td>Right UE</td> <td>Left UE</td> <td>Right LE</td> <td>Left LE</td> </tr> <tr> <td>Prox      Dist</td> <td>Prox      Dist</td> <td>Prox      Dist</td> <td>Prox      Dist</td> </tr> <tr> <td>Neck Flexors/Extens.</td> <td>Respiratory muscles</td> <td colspan="2">Quadriplegia/whole body paralysis</td> <td>Facial muscles</td> </tr> <tr> <td colspan="5">Describe weakness distribution: _____</td> </tr> </table>                                                                                        |                     |                                   |                                                                                 |                | Distribution of weakness at first onset (e.g. first noted weakness) |  | Symmetric | Asymmetric | Unknown | Check all that apply: | Right UE | Left UE | Right LE | Left LE | Prox      Dist | Prox      Dist | Prox      Dist | Prox      Dist | Neck Flexors/Extens. | Respiratory muscles | Quadriplegia/whole body paralysis |  | Facial muscles | Describe weakness distribution: _____            |  |  |  |  |                                                      |  |  |  |  |
| Distribution of weakness at first onset (e.g. first noted weakness)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | Symmetric                         | Asymmetric                                                                      | Unknown        |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Check all that apply:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Right UE            | Left UE                           | Right LE                                                                        | Left LE        |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Prox      Dist      | Prox      Dist                    | Prox      Dist                                                                  | Prox      Dist |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Neck Flexors/Extens.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Respiratory muscles | Quadriplegia/whole body paralysis |                                                                                 | Facial muscles |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Describe weakness distribution: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Nature of weakness onset:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Ascending                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Descending          | Acute/whole limb                  | Unknown                                                                         |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Approximate time interval to maximal weakness: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| <table border="0" style="width: 100%;"> <tr> <td colspan="2"><u>Distribution</u> of weakness at <b>maximal</b> weakness</td> <td>Symmetric</td> <td>Asymmetric</td> <td>Unknown</td> </tr> <tr> <td rowspan="2">Check all that apply:</td> <td>Right UE</td> <td>Left UE</td> <td>Right LE</td> <td>Left LE</td> </tr> <tr> <td>Prox      Dist</td> <td>Prox      Dist</td> <td>Prox      Dist</td> <td>Prox      Dist</td> </tr> <tr> <td>Neck Flexors/Extens.</td> <td>Respiratory muscles</td> <td colspan="2">Quadriplegia/whole body paralysis</td> <td>Facial muscles</td> </tr> <tr> <td colspan="5">Describe weakness distribution at maximum: _____</td> </tr> <tr> <td colspan="5">Approximate date of maximal weakness: ____/____/____</td> </tr> </table> |                     |                                   |                                                                                 |                | <u>Distribution</u> of weakness at <b>maximal</b> weakness          |  | Symmetric | Asymmetric | Unknown | Check all that apply: | Right UE | Left UE | Right LE | Left LE | Prox      Dist | Prox      Dist | Prox      Dist | Prox      Dist | Neck Flexors/Extens. | Respiratory muscles | Quadriplegia/whole body paralysis |  | Facial muscles | Describe weakness distribution at maximum: _____ |  |  |  |  | Approximate date of maximal weakness: ____/____/____ |  |  |  |  |
| <u>Distribution</u> of weakness at <b>maximal</b> weakness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | Symmetric                         | Asymmetric                                                                      | Unknown        |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Check all that apply:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Right UE            | Left UE                           | Right LE                                                                        | Left LE        |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Prox      Dist      | Prox      Dist                    | Prox      Dist                                                                  | Prox      Dist |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Neck Flexors/Extens.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Respiratory muscles | Quadriplegia/whole body paralysis |                                                                                 | Facial muscles |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Describe weakness distribution at maximum: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |
| Approximate date of maximal weakness: ____/____/____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                   |                                                                                 |                |                                                                     |  |           |            |         |                       |          |         |          |         |                |                |                |                |                      |                     |                                   |  |                |                                                  |  |  |  |  |                                                      |  |  |  |  |

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

**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 |       |        | Result      |          | If positive: |            |            |
|----------------|------|--------------|-------|--------|-------------|----------|--------------|------------|------------|
|                |      | (Check one)  |       |        | (Check one) |          |              |            |            |
|                |      | Bacterial    | Viral | Fungal | No growth   | Positive | Organism 1   | Organism 2 | Organism 3 |
|                |      |              |       |        |             |          |              |            |            |
|                |      |              |       |        |             |          |              |            |            |
|                |      |              |       |        |             |          |              |            |            |
|                |      |              |       |        |             |          |              |            |            |
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\*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 |
|----------------|------|----------------|---------|----------------|------------|
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Case Data Collection Worksheet

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



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

FINAL BRIGHTON CASE DEFINITION CLASSIFICATION: (See Appendix

Guillain-Barre Syndrome

**0** Level 1

**0** Level 2

**0** Level 3

**0** Level 4

**0** Level 5

Fisher Syndrome:

**0** Level 1

**0** Level 2

**0** Level 3

**0** Level 4

**0** 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