

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: **01/31/2026**

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 ☐ Hispanic or Latino
☐ Middle Eastern or North African ☐ Native Hawaiian or Other Pacific Islander ☐ White (check all that apply)
8. Date of onset of limb weakness ____/____/____ (mm/dd/yyyy)
9. Was patient admitted to a hospital? ☐ yes ☐ no ☐ unknown
10. Date of admission to **first** hospital ____/____/____
11. Date of discharge from **last** hospital ____/____/____ (or ☐ still hospitalized at time of form submission)
12. Did the patient die from this illness? ☐ yes ☐ no ☐ unknown
13. If yes, date of death ____/____/____

SIGNS/SYMPTOMS/CONDITION:						
	Right Arm			Left Arm	Right Leg	Left Leg
14. Weakness? [indicate yes(y), no (n), unknown (u) for each limb]	Y	N	U	Y	N	U
14a. Tone in affected limb(s) [flaccid, spastic, normal for each limb]	<input type="checkbox"/> flaccid	<input type="checkbox"/> spastic	<input type="checkbox"/> normal	<input type="checkbox"/> flaccid	<input type="checkbox"/> spastic	<input type="checkbox"/> normal
	<input type="checkbox"/> unknown	<input type="checkbox"/> unknown	<input type="checkbox"/> unknown	<input type="checkbox"/> unknown	<input type="checkbox"/> unknown	<input type="checkbox"/> unknown
	Yes	No	Unk			
15. Was patient admitted to ICU?				16. If yes, admit date: ____/____/____		
In the 4-weeks BEFORE onset of limb weakness, did patient:	Yes	No	Unk			
17. Have a respiratory illness?				18. If yes, onset date ____/____/____		
19. Have a gastrointestinal illness (e.g., diarrhea or vomiting)?				20. If yes, onset date ____/____/____		
21. Have a fever, measured by parent or provider $\geq 38.0^{\circ}\text{C}/100.4^{\circ}\text{F}$?				22. If yes, onset date ____/____/____		
23. Have pain in neck or back?				24. If yes, onset date ____/____/____		
25. At onset of limb weakness, does patient have any underlying illnesses?				26. If yes, list:		

Travel history:	
27. Did the patient travel outside of the US in the 30 days before the onset of limb weakness?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
27a. If yes, list country/countries	

Polio vaccination history:	
28. Has the patient received polio vaccine?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
28a. How many doses of inactivated polio vaccine (IPV) are documented to have been received by the patient before the onset of limb weakness?	____ doses <input type="checkbox"/> unknown
28b. How many doses of oral polio vaccine (OPV) are documented to have been received by the patient before the onset of limb weakness?	____ doses <input type="checkbox"/> unknown
28c. 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 <input type="checkbox"/> unknown

Magnetic Resonance Imaging:

29. Was MRI of spinal cord performed? ☐ yes ☐ no ☐ unknown 30. If yes, date of spine MRI: __/__/____

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

32. Was MRI of brain performed? ☐ yes ☐ no ☐ unknown 33. If yes, date of brain MRI: __/__/____

CSF examination: 34. Was a lumbar puncture performed? ☐ yes ☐ no ☐ unknown

If yes, complete 34 (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
34a. CSF from LP1									
34b. CSF from LP2									

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

Acute Flaccid Myelitis Outcome – complete follow-up for all reported persons under investigation (PUI) at 60 days after onset of limb weakness.

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

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

36a. Date of death: ____/____/____ (mm/dd/yyyy)

37. **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)

38. **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.

39. **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. Dependent totally in mobility with marked impairment of lower limbs.

40. **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

41. **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

42. **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>)