Appendix 1. Chart Abstraction Form

Form Approved
CDC ID:_____
OMB No. 0920-XXXX
Exp. Date XX/XX/XXXX

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:_____

Demographic Information

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):

Timeline and Outcome

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**)**:_____)
Discharged to chronic care or rehabilitation facility (Date:_____)
Discharged to home (Date:_____)
Still hospitalized

Prodrome Illness Symptoms

Diarrhea Yes No Unk Vomiting Yes No Unk Bloody stool Yes No Unk Rash Yes No Unk
Fever Yes No Unk Cough Yes No Unk Headache Yes No Unk Abdominal Pain Yes No Unk
Sore Throat Yes No Unk Joint pains/aches Yes No Unk Other _____

Duration of prodromal symptoms: _____ days

Location of patient in 7 days before prodromal symptoms:

Past Medical and Neurological History

Past Medical and Neurological History (include EtOH, tobacco, drug use):

Exposure History

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 Unk
What date of onset?: ____/____/_____

Any gastrointestinal infection in the last 6 weeks? Yes No Unk
What date of onset?: ____/____/_____

Any vaccinations received in the last 6 weeks? Yes No Unk
If yes, date of receipt: __ / __/ _____
If yes, vaccine(s)_administered_____

Ill household contacts in the past 6 weeks? Yes No Unk
Nature of illness:

Toxic/Chemical Exposures

1. Did patient recall taking any herbal or folk remedies during 2 weeks prior to illness Yes No Unknown
If YES, Remedy 1: _____
Remedy 2: _____

3. Did patient recall eating any wild picked plants (like. buckthorn or Karwinskia Humboldt pictured below) during 2 weeksprior to illness onset? Yes No Unknown
If YES, Plant 1: _____
Plant 2: _____

Neuro Symptoms

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: _____

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: _____

Distribution of weakness at **maximal** 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 dyspnnea 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: _____

Hospital Course

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 _____/mm3 RBC_____/mm3 Protein_____ mg/dL Glucose_____ mg/dL

WBC differential: Neutrophils_____% Lymphocytes_____% Monocytes_____% Eosinophils_____%

Date CSF 2: __/__/____ WBC _____/mm3 RBC_____/mm3 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 <u>treatments</u> or <u>procedures</u> 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** (Check one)			**Result** (Check one)		If positive:		
		Bacterial	Viral	Fungal	No growth	Positive	Organism 1	Organism 2	Organism 3

*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**

*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

- O Level I
- O Level 2
- O Level 3
- O Level 4
- O Level 5

Fisher Syndrome:

- O Level I
- O Level 2
- O Level 3
- O Level 4
- O Level 5

APPENDIX I: BRIGHTON CASE DEFINITION CRITERIA

Guillain-Barré Syndrome

Level I (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 / mm3
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/mm3 (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/mm3)
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

<u>Level 2</u>

1. Criteria 1, 2, and 3 for Level 1 fulfilled
   AND
2. Cerebrospinal fluid (CSF) with a total white cell count <50 cells/mm3 (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

<u>Level 3</u>

1. Criteria 1, 2, 3, 6, and 7 for Level 1 fulfilled

<u>Levels 4 and 5 as for GBS</u>