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: _____

If transferred, name additional hospital(s)_____ State: _____ County: _____

Patient name_____

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

1. Today's date_____ (*mm/dd/yyyy)* **2**. State assigned patient ID: _____

3. Sex: ☐ M ☐F **4.** Date of birth _____ Residence: **5**. State_____ **6.** County_____

7. Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White *(check all that apply)*

8. Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

8. Date of onset of limb weakness _____ *(mm/dd/yyyy)*

9. Was patient admitted to a hospital? ☐yes ☐no ☐unknown **11.** Date of admission to **first** hospital _____

12. Date of discharge from **last** hospital _____(or ☐ still hospitalized at time of form submission)

13. Did the patient die from this illness? ☐yes ☐no ☐unknown **14**. If yes, date of death_____

Signs/symptoms/condition:	Right Arm	Left Arm	Right Leg	Left Leg
15. Weakness? [*indicate yes(y), no (n), unknown (u)* ***for each limb***]	Y☐ N☐ U☐	Y☐ N☐ U☐	Y☐ N☐ U☐	Y☐ N☐ U☐
15a. Tone in **affected** limb(s) [*flaccid, spastic, normal* ***for each limb***]	☐ flaccid ☐ spastic ☐ normal ☐ unknown	☐ flaccid ☐ spastic ☐ normal ☐ unknown	☐ flaccid ☐ spastic ☐ normal ☐ unknown	☐ flaccid ☐ spastic ☐ normal ☐ unknown

	Yes	No	Unk	
16. Was patient admitted to ICU?	☐	☐	☐	**17.** If yes, admit date: _____
17a. Was patient intubated?	☐	☐	☐	
In the 4-weeks **BEFORE onset** of **limb weakness**, did patient:	Yes	No	Unk	
18. Have a respiratory illness?	☐	☐	☐	**19**. If yes, onset date _____
20. Have a gastrointestinal illness (e.g., diarrhea or vomiting)?	☐	☐	☐	**21**. If yes, onset date _____
22. Have a fever, measured by parent or provider ≥38.0°C/100.4°F?	☐	☐	☐	**23**. If yes, onset date _____
24. Have pain in neck or back?	☐	☐	☐	**25.** If yes, onset date _____
26. At onset of limb weakness, does patient have any underlying illnesses?	☐	☐	☐	**27.** If yes, list:

Magnetic Resonance Imaging:

28. Was MRI of spinal cord performed? ☐ yes ☐ no ☐ unknown **29.** If yes, date of spine MRI: _____

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

31. Was MRI of brain performed? ☐ yes ☐ no ☐ unknown **32.** If yes, date of brain MRI: _____

CSF examination: **33**. Was a lumbar puncture performed? ☐ yes ☐ no ☐ unknown

If yes, complete 33 (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
33a. CSF from LP1									
33b. CSF from LP2									

	Yes	No	Unk	
33c. Was a respiratory viral panel completed?	☐	☐	☐	If positive, list result(s): _____

Polio risk:

34. Did patient travel, or have contact with someone who traveled, outside the US in the 30 days before onset of limb weakness? _____ yes no unknown

34a. If yes, location(s): _____

35. If available, has the patient received polio vaccine? If so, how many doses were received before limb weakness onset _____ (1, 2, 3, or 4)?