County of Los Angeles Public Health
Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone), 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

Guillain-Barré Syndrome (GBS) Case Report Form

Please instruct your laboratory to hold all remaining clinical specimens (CSF, blood, stool, respiratory) for specialized testing by the California Department of Public Health. We will coordinate transfer of specimens when you submit this case report form.

Patient Name-Last	First	Middle Initial	Date of birth	Age	Sex ☐ M ☐ F

Address- Number, Street, Apt #	City	State	ZIP Code

Telephone number Home ( )	Work ( )	Cell ( )

Race (check one)
☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:_____

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

PRESENT ILLNESS

Onset date	Diagnosis date	Hospitalized? ☐ Yes ☐ No	Admit date	Medical record no.	Hospital name

Signs and symptoms (check all that apply):

- ☐ Acute onset of bilateral and relatively symmetric flaccid weakness or paralysis of the limbs with or without involvement of respiratory or cranial nerve-innervated muscles
- ☐ Decreased or absent deep tendon reflexes in affected limbs
- ☐ Electrophysiologic findings consistent with GBS
- ☐ Presence of cytoalbuminologic dissociation (elevation of CSF protein concentration above the laboratory normal, with CSF WBC <50 cells/mm^3)
- ☐ Absence of an alternative diagnosis for weakness

Specify any major comorbid conditions (e.g. malignancy, chronic kidney disease, autoimmune disease): _____

_____

Has the patient ever been diagnosed with GBS before? ☐ Yes ☐ No

If Yes, specify year of diagnosis. _____

Symptoms of possible infection that occurred in the six weeks prior to onset of GBS (check all that apply):

- ☐ Fever (≥ 38° C) ☐ Diarrhea ☐ Nausea/vomiting
- ☐ Upper respiratory (sore throat, rhinorrhea, congestion)
- ☐ Lower respiratory (cough, shortness of breath, wheezing)
- ☐ Other Specify. _____

Is the patient currently in the ICU? ☐ Yes ☐ No ☐ Unk

Outcome? ☐ Still at admitting hospital

☐ Discharged to: ☐ Home ☐ Another healthcare facility
Specify date. _____/_____/_____

☐ Death Specify date died. _____/_____/_____

VACCINE HISTORY

Did this patient receive the **seasonal** influenza vaccine after September 2009? ☐ Yes ☐ No ☐ Unk

If Yes, ☐ Injected ☐ Nasal spray ☐ Unk Specify date administered (if known): _____/_____/_____

Did this patient receive the **pandemic (H1N1)** 2009 influenza vaccine? ☐ Yes ☐ No ☐ Unk

If Yes, ☐ Injected ☐ Nasal spray ☐ Unk Specify date(s) administered (if known) : Dose 1 _____/_____/_____ Dose 2 _____/_____/_____

Did this patient receive any other vaccines in the six weeks prior to GBS diagnosis? ☐ Yes ☐ No ☐ Unk

If Yes, specify. _____

DIAGNOSTIC TESTS

Did this patient have any of the following procedures/studies performed? ☐ Head CT/MRI ☐ Lumbar puncture ☐ EMG (electromyography)

Was the patient diagnosed with any of the following GBS-associated infections in the two months prior to onset of GBS?

☐ *Campylobacter* ☐ Enterovirus ☐ Influenza ☐ CMV ☐ EBV ☐ Other: _____

Did this patient have any of the following clinical specimens sent to the laboratory?

☐ CSF ☐ Blood ☐ Stool ☐ Respiratory specimen (sputum, BAL, NP swab, ET aspirate)

REMARKS

CONTACT INFORMATION

Physician name	Office/Pager number ( )	Email address	Date reported

To report a case, fax this form to: Los Angeles County Public Health - Acute Communicable Disease Control
Phone 213-240-7941 Fax 213-482-4856

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