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)?