# 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_____

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***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)?