Attachment #2

GUAM PUBLIC HEALTH LABORATORY
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
123 Chalan Kareta, Mangilao, GUAM 96913
Telephone: (671) 735-7158/7141

GPHL LABORATORY NUMBER

DATE RECEIVED

(PLEASE PRINT LEGIBLY)

ORDERING/PRIMARY PHYSICIAN:

ADDRESS:
Street:
City: State:
Country: Zip Code:
Phone No.:

SUBMITTING LABORATORY:

ADDRESS:
Street:
City: State:
Country: Zip Code:
Phone No.:

CLINICAL DIAGNOSIS

CATEGORY OF AGENT SUSPECTED

I. PATIENT IDENTIFICATION

LAST NAME | FIRST NAME AND MIDDLE INITIAL

RESIDENT ADDRESS (Physical place of residence Street, City, Zip Code)

Street:

City: | Zip Code:

PHONE NO.:

OCCUPATION | RACE | DATE OF BIRTH | SEX

DATE OF ONSET | LABORATORY EXAMINATION REQUESTED

SPECIFIC AGENT SUSPECTED

II. SPECIMEN INFORMATION

1. SOURCE OF SPECIMEN
☐ HUMAN
☐ OTHER (Specify):

2. ORIGINAL MATERIAL
*TYPE OF SPECIMEN:
DATE OF COLLECTION:
TRANSPORT MEDIUM:
*SPECIFY SITE OF COLLECTION

3. SEROLOGY OF SPECIMEN
COLLECTION DATE:
☐ ACUTE (S1):
☐ CONVALESCENT (S2):
☐ S3:
☐ S4:
☐ OTHER (Specify):

4. SEROLOGY OF SPECIMEN
☐ PURE ISOLATE
☐ MIXED CULTURE
☐ OTHER (Specify):
DATE OF ORIGINAL CULTURE:
PRIMARY ISOLATON MEDIA:
COLLECTON SITE OF ORIGINAL SPECIMEN:
DATE OF CULTURE SUBMITTED AND TRANSPORT MEDIUM USED:
SUSPECTED IDENTIFICATION:
OTHER ORGANISMS FOUND:
OTHER INFORMATION:

III. CLINIC HISTORY

1. CLINICAL SIGNS AND SYMPTOMS
☐ FEVER
☐ EXANTHEMA (Specify Type):
☐ RESPIRATORY SIGNS:
☐ CENTRAL NERVOUS SYSTEM INVOLVEMENT:
☐ GASTROINTESTINAL INVOLVEMENT:

2. ADDITIONAL INFORMATION
TRAVEL HISTORY:
IMMUNIZATIONS:
ANTIBIOTIC THERAPY:

3. PREVIOUS LABORATORY RESULTS/OTHER INFORMATION

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES BCDC GPHL USE ONLY

DATE OF REPORT:

FORM GPHL
DPHSS_FRM_05/18/16

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: _____

----------***DETACH and transmit only lower portion to limbweakness@cdc.gov if sending to CDC***----------

Acute Flaccid Myelitis: Patient Summary Form

Form Approved
OMB No. 0920-0009
Exp Date: 06/30/2019

Please send the following information along with the patient summary form (check information included):
☐ *History and physical (H&P)* ☐ *MRI report* ☐ *MRI images* ☐ *Neurology consult notes* ☐ *EMG report (if done)*
☐ *Infectious disease consult notes (if available)* ☐ *Vaccination record* ☐ *Diagnostic laboratory reports*

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

9. Date of onset of limb weakness __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*

10. 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: __ __/__ __/__ __ __ __
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. Travel outside the US?				**25.** If yes, list country:
26. At onset of limb weakness, does patient have any underlying illnesses?				**27.** If yes, list:

Other patient information:

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

30. Was MRI of brain performed? ☐yes ☐no ☐unknown **31.** If yes, date of brain MRI: __ __/__ __/__ __ __ __

CSF examination: **32.** Was a lumbar puncture performed? ☐yes ☐no ☐unknown

If yes, complete 32 (a,b) *(If more than 2 CSF examinations, list the first 2 performed)*

	Date of lumbar puncture	WBC/mm³	% neutrophils	% lymphocytes	% monocytes	% eosinophils	RBC/mm³	Glucose mg/dl	Protein mg/dl
32a. CSF from LP1									
32b. CSF from LP2									

Acute Flaccid Myelitis Outcome – 60-day follow-up (*completed at least 60 days after onset of limb weakness*)

33. Date of 60-day follow-up: __/__/____ *(mm/dd/yyyy)*

34. Sites of Paralysis: ☐ Spinal ☐ Bulbar ☐ Spino-bulbar **35.** Specific sites: _____

36. 60-day residual: ☐ None ☐ Minor (any minor involvement) ☐ Significant (≤2 extremities, major involvement) ☐ Severe (≥3 extremities and respiratory involvement) ☐ Death ☐ Unknown

37. Date of death: __/__/____ *(mm/dd/yyyy)*

Acute Flaccid Myelitis case definition

(http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/2017PS/2017PSFin al/17-ID-01.pdf)

Clinical Criteria

An illness with onset of acute flaccid limb weakness

Laboratory Criteria

- Confirmatory Laboratory Evidence: a magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter*† and spanning one or more vertebral segments
- Supportive Laboratory Evidence: cerebrospinal fluid (CSF) with pleocytosis (white blood cell count >5 cells/mm^3)

Case Classification

Confirmed:

- Clinically compatible case AND
- Confirmatory laboratory evidence: MRI showing spinal cord lesion largely restricted to gray matter*† and spanning one or more spinal segments

Probable:

- Clinically compatible case AND
- Supportive laboratory evidence: CSF showing pleocytosis (white blood cell count >5 cells/mm^3).

** Spinal cord lesions may not be present on initial MRI; a negative or normal MRI performed within the first 72 hours after onset of limb weakness does not rule out AFM. MRI studies performed 72 hours or more after onset should also be reviewed if available.*

† Terms in the spinal cord MRI report such as "affecting mostly gray matter," "affecting the anterior horn or anterior horn cells," "affecting the central cord," "anterior myelitis," or "poliomyelitis" would all be consistent with this terminology.

Comment

To provide consistency in case classification, review of case information and assignment of final case classification for all suspected AFM cases will be done by experts in national AFM surveillance. This is similar to the review required for final classification of paralytic polio cases.

Acute Flaccid Myelitis specimen collection information

(https://www.cdc.gov/acute-flaccid-myelitis/hcp/instructions.html)

Acute Flaccid Myelitis job aid

(https://www.cdc.gov/acute-flaccid-myelitis/downloads/job-aid-for-clinicians.pdf)

Instructions for Completing the AFM Patient Summary Form

GENERAL. Clinicians should remain vigilant and send information to their state or local health department for all patients with acute onset of neurologic illness associated with limb weakness that meet the clinical criteria for AFM (as highlighted on page 3).

a. Clinicians should send information about patients who meet the clinical criteria regardless of any laboratory and MRI results.
b. The AFM *Patient Summary Form* should be completed by the state or local health department, in conjunction with a clinician who provided care to the patient during the neurologic illness.

CDC requests that state health departments send the *Patient Summary Form,* along with additional clinical information, to CDC for case classification and to help monitor these cases at the national level. AFM neurology experts will classify suspect cases of AFM according to the Council of State and Territorial Epidemiologists (CSTE) AFM case definition using the requested clinical information: admission and discharge notes, MRI report, MRI images, neurology consult notes, infectious disease consult notes, vaccination record, diagnostic laboratory results, and EMG report if done and available. When sending this information, please indicate the information included with the *Patient Summary Form* in the box at the top of the form.

Demographics

1. **TODAY'S DATE.** Date that completion of the patient summary form is initiated.
2. **STATE ASSIGNED ID.** Alpha/numeric
3. **SEX.** Indicate whether the case-patient is male or female.
4. **DATE OF BIRTH.** Case-patient birth date.
5. **RESIDENCE.** State in which case-patient resides.
6. **COUNTY.** County in which case-patient resides.
7. **RACE.** Self-reported race of case-patient; more than one option may be reported.
8. **ETHNICITY.** Self-reported ethnicity of case-patient.
9. **DATE OF ONSET OF LIMB WEAKNESS.** Limb weakness onset date of case-patients.
10. **HOSPITALIZED?** Was case-patient hospitalized?
11. **DATE HOSPITALIZED.** Date case-patient FIRST hospitalized.
12. **DATE DISCHARGED.** Date case-patient discharged from LAST hospital (indicate if still hospitalized).
13. **DIED?** Did case-patient die from this illness?
14. **DATE OF DEATH.** Case-patient's date of death.

Signs/symptoms/condition at ANY time during the illness

15. **WEAKNESS.** Specify for each limb (arms and or legs) if there was noted acute onset of weakness.

    15a. **TONE IN AFFECTED LIMB.** Specify for each limb (arms and or legs) the tone in the limb with weakness (select one option per limb)

16. **ICU?** Was case-patient admitted to the ICU?
17. **DATE ICU.** Date case-patient admitted to ICU.

Signs/symptoms/condition in the 4-weeks BEFORE onset illness

18. **RESPIRATORY ILLNESS?** Did case-patient have a respiratory illness within the 4-week period before onset of limb weakness?
19. **RESPIRATORY ILLNESS ONSET DATE.** Case-patient's respiratory onset date.
20. **GASTROINTESTINAL ILLNESS?** Did case-patient have a gastrointestinal illness (e.g., diarrhea or vomiting) within the 4-week period before onset of limb weakness?
21. **GASTROINTESTINAL ILLNESS ONSET DATE.** Case-patient's gastrointestinal illness onset date.
22. **FEVER?** Did case-patient have a fever (≥38°C/100.4°F), measured by parent or provider, within the 4-week period before onset of limb weakness?
23. **FEVER ONSET DATE.** Case-patient's fever onset date.
24. **TRAVEL OUTSIDE U.S.?** Did case-patient travel outside the U.S. within the 4-week period before onset of limb weakness?
25. **IF YES, LIST.** If any, list the country(s) visited by the case-patient.
26. **UNDERLYING ILLNESSES?** Does the case-patient have any underlying illnesses?
27. **IF YES, LIST.** List the case-patient's underlying illness(es).

Other patient information

28. **MRI OF SPINAL CORD PERFORMED?** Indicate whether case-patient had an MRI of the spinal cord performed.
29. **DATE SPINAL MRI PERFORMED.** Date of the case-patient's spinal cord MRI.
30. **MRI OF BRAIN PERFORMED?** Indicate whether case-patient had an MRI of the brain performed.
31. **DATE BRAIN MRI PERFORMED.** Date of the case-patient's brain MRI.

CSF examination

32. **LUMBAR PUNCTURE PERFORMED?** Indicate if there was a CSF examination done (option for up to two. If more than 2 CSF examinations performed, list the first 2 performed).
    32a. **CSF from LP1.** Complete findings for lumbar puncture 1.
    32b. **CSF from LP2.** Complete findings for lumbar puncture 1.

Acute Flaccid Myelitis Outcome

Follow-up of suspect AFM cases, conducted at least 60 days after onset of limb weakness, will help ascertain if there is any residual paralysis. Follow-up can be done by contacting the case-patient/family for answers to the questions, reviewing medical records, or contacting the case-patient's regular healthcare provider.

33. **DATE OF 60-DAY FOLLOW-UP.** Date that 60-day follow-up of the case-patient is initiated.
34. **SITES OF PARALYSIS.** Indicate the sites where the case-patient had paralysis.
35. **SPECIFIC SITES.** Specify the specific sites where the case-patient had paralysis.
36. **60-DAY RESIDUAL.** Indicate the status of the case-patient at the point of the 60-day follow-up.
37. **DATE OF DEATH.** Case-patient's date of death during 60-day follow-up.

Case Definition

In June 2015, the Council of State and Territorial Epidemiologists (CSTE) adopted a standardized case definition for AFM that is used by CDC to classify suspected cases as confirmed or probable. The case definition was updated in June 2017 and is presented below.

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