

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: _____

-----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 8. Ethnicity: ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White (check all that apply) ☐ 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]	<input type="checkbox"/> flaccid	<input type="checkbox"/> spastic	<input type="checkbox"/> normal	<input type="checkbox"/> unknown	<input type="checkbox"/> flaccid	<input type="checkbox"/> spastic	<input type="checkbox"/> normal	<input type="checkbox"/> unknown	<input type="checkbox"/> flaccid	<input type="checkbox"/> spastic	<input type="checkbox"/> normal	<input type="checkbox"/> 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 $\geq 38.0^{\circ}\text{C}/100.4^{\circ}\text{F}$?				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/mm ³	% neutrophils	% lymphocytes	% monocytes	% eosinophils	RBC/mm ³	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/2017PSFinal/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/mm³)

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/mm³).

* 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>)

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333.