CDC ID _____

Form to be completed by, or in conjunction with, a physician who provided care to the patient during the neurological illness.

Patient Demographics

*Last Name:*_____ *First Name:*_____ *Middle Name:*_____

DOB: __ __ / __ __ /__ __ __ __ *Age: _____ ☐ years ☐ months* *Sex: ☐ Female ☐ Male ☐ Unknown*

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes *Date of Death: __ __ / __ __ /__ __ __ __*

*Street Address 1:*_____ *Street Address 2:*_____

*City:*_____ *State:*_____ *Zip Code:*_____ *County:*_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ *Cell Phone: (__ __ __) - __ __ __ - __ __ __ __* *E-mail:* _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

Reporting Facility

*Facility Name:*_____

Facility City: _____ *Facility County:* _____

*Physician Name:*_____ *Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____*

PART I. Acute Neurological Illness with Limb Weakness in Children: Patient Summary Form

Confirmation of case:	Yes	No	Unknown
a. Neurological findings (upon examination by clinician) include focal limb weakness			
b. MRI of spinal cord demonstrates spinal lesion largely restricted to the gray matter			
c. Age at onset of limb weakness is 21 years or less			
d. Onset of limb weakness was August 1, 2014 or later			

Answer to ALL 4 criteria must be YES. If yes, continue to Part II on pages 2 - 5.

CDC ID _____

PART II. Acute Neurological Illness with Limb Weakness in Children: Patient Summary Form

Form to be completed by, or in conjunction with, a physician who provided care to the patient during the neurological illness.
Once completed, submit to Health Department (HD). HD can also facilitate specimen testing.

1.Today's date__ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **2**.Name of person completing form: _____

3. Affiliation_____Phone: _____Email: _____

4. Name of physician who can provide additional clinical/lab information, if needed _____

5. Affiliation_____ Phone: _____ Email: _____

6. Name of main hospital that provided patient's care:_____ **7**.State: _____ **8**.County: _____

9. Patient ID: _____**10**. State ID: _____ **11**. Patient's sex: ☐ M ☐F

12. Patient's age: _____years AND _____months Patient's residence: **13**. State_____ **14.** County_____

15. Race: ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐American Indian or Alaska Native ☐White *(check all that apply)* **16**. Ethnicity: ☐Hispanic ☐Non-Hispanic

17. Date of onset of limb weakness: __ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **18**. Was patient admitted to a hospital? ☐yes ☐no ☐unknown

19. Date of admission to **first** hospital__ __/__ __/__ __ __ __ **20.**Date of discharge from **last** hospital__ __/__ __/__ __ __ __(or ☐ still hospitalized)

21. Current clinical status: ☐recovered ☐not recovered, but improved ☐not improved ☐Deceased: **22**.Date of death__ __/__ __/__ __ __

Signs/symptoms/condition at ANY time during the illness:				
	Right Arm	Left Arm	Right Leg	Left Leg
23.Acute limb weakness [*indicate yes(y), no (n), unknown (u)* ***for each limb***]	Y N U	Y N U	Y N U	Y N U
24. Motor weakness grade for **affected** limb(s), at **peak** severity: *0–5 /5* ‡				
25. Date of that examination (**peak** severity) *(mm/dd)*	__ __/__ __	__ __/__ __	__ __/__ __	__ __/__ __
26. Motor weakness grade for **affected** limb(s), **most recent** exam: *0–5 /5* ‡				
27. Date of that most recent examination *(mm/dd)*	__ __/__ __	__ __/__ __	__ __/__ __	__ __/__ __
28. Reflexes in the **affected** limb(s): (on day of **peak** weakness) *0 – 4+* ¶				
29. Any numbness in the **affected** limb(s)? (at any time during illness)	Y N U	Y N U	Y N U	Y N U
30. Any pain or burning in the **affected** limb(s)? (at any time during illness)	Y N U	Y N U	Y N U	Y N U

	Yes	No	Unknown
31. Sensory level(s) present in the torso? (at any time during illness)			
32. Clinical involvement of cranial nerve(s)? (at any time during illness)			
If yes, indicate CN(s) involved: CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral			
CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral			
33. Any pain or burning in neck or back? (at any time during illness)			
34. Bowel or bladder incontinence? (at any time during illness)			
35 .Cardiovascular instability (e.g, labile blood pressure, alternating tachy/bradycardia)? (at any time during illness)			
36. Change in mental status (e.g, confused, disoriented, encephalopathic)? (at any time during illness)			
37. Seizure(s)? (at any time during illness)			
38. Received care in ICU because of neurological condition? (at any time during illness)			
39. Received invasive ventilatory support (e.g, intubation, tracheostomy) because of neurological condition?			

‡ 0/5: no contraction; 1/5: muscle flicker, but no movement; 2/5: movement possible, but not against gravity; 3/5: movement possible against gravity, but not against resistance by examiner; 4/5: movement possible against some resistance by examiner; 5/5: normal strength. If this number grading not possible, please record weakness as mild, moderate, severe, or unknown.

¶ 0, absent; 1+, hyporeflexia; 2+, normal; 3+, hyperreflexia; 4+, hyperreflexia with clonus. If this number grading is not indicated in medical chart, please record on this form using this scale, based on description of reflexes in medical chart.

Other patient information:

Within the 4-week period **BEFORE onset** of **limb weakness**, did patient:	Yes	No	Unk	
40. Have a respiratory illness?				**41**. If yes, date of onset __ __/__ __/__ __ __ __
42. Have a fever, measured by parent or provider and ≥ 38.0°C/100.4°F?				**43**. If yes, date of onset __ __/__ __/__ __ __ __
44. Receive oral, IM or IV steroids?				
45. Receive any other systemic Immunosuppressant(s)?				**46.** If yes, list:
47. Receive any intramuscular injections?				**48.** If yes, date __ __/__ __/__ __ type: site(s):
49. Undergo a surgical procedure?				**50.** If yes, date __ __/__ __/__ __ type:
51. Travel outside the US?				**52.** If yes, list country
53. Does patient have any underlying illnesses?				**54.** If yes, list
55. On the **day of onset of limb weakness**, did patient have a fever? (see definition above)				

Polio vaccination history:	
56. How many doses of **inactivated polio vaccine (IPV**) are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
57. How many doses of **oral polio vaccine (OPV)** are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
58. If you do not have documentation of the *type* of polio vaccine received: **a**.What is total number of **documented** polio vaccine doses received before onset of weakness?	_____doses ☐unknown
b.Were any of these doses administered outside the US?	☐yes ☐no ☐unknown

Neuroradiographic findings: (*Indicate based on <u>most abnormal</u> study)*

<u>MRI of spinal cord</u> **59**. Date of study __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*
60. Levels imaged: ☐cervical ☐thoracic ☐lumbosacral ☐unknown
61. Gadolinium used? ☐yes ☐no ☐unknown

62. Location of lesions:	☐cervical cord ☐thoracic cord ☐conus ☐cauda equina ☐unknown	Levels of cord affected (if applicable): **63**. Cervical: _____ **64.** Thoracic: _____
For **cervical and thoracic cord** lesions	**65.** What areas of spinal cord were affected?	☐gray matter ☐white matter ☐both ☐unknown
	66. Was there cord edema?	☐yes ☐no ☐unknown
	67. Site of lesion(s):	☐right ☐left ☐bilateral ☐unknown
For **cervical, thoracic cord or conus** lesions	**68**. Did any lesions enhance with GAD?	☐yes ☐no ☐unknown
For **cauda equina** lesions	**69**. Did the **ventra**l nerve roots enhance with GAD?	☐yes ☐no ☐unknown **70**. If yes, which nerve roots?_____
	71. Did the **dorsal** nerve roots enhance with GAD?	☐yes ☐no ☐unknown **72.** If yes, which nerve roots?_____

MRI of brain **73.** Date of study __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*

74. Gadolinium used? ☐ yes ☐no ☐unknown

75. Any **supratentorial** (i.e, cortical, subcortical, basal ganglia, or thalamic) lesions	☐yes ☐no ☐unknown	
	76.If yes, indicate location(s)	☐cortex ☐subcortex ☐basal ganglia ☐thalamus ☐unknown
	77. If yes, did any lesions enhance with GAD?	☐yes ☐no ☐unknown
78. Any **brainstem** lesions?	☐yes ☐no ☐unknown	
	79. If yes, indicate location:	☐midbrain ☐pons ☐medulla ☐unknown
	80. If yes, did any lesions enhance with GAD?	☐yes ☐no ☐unknown
81. Any **cranial nerve** lesions?	☐yes ☐no ☐unknown	
	82. If yes, indicate which CN(s):	CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
		CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
	83. If yes, did any lesions enhance with GAD?	☐yes ☐no ☐unknown
84. Any lesions affecting the **cerebellum**?	☐yes ☐no ☐unknown	

85. Was an EMG done? ☐yes ☐no ☐unknown If yes, date __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*

86. If yes, was there evidence of acute motor neuropathy, motor neuronopathy, motor nerve or anterior horn cell involvement?☐yes ☐no ☐unkn

CSF examination: *(If more than two examinations, list earliest and then most abnormal)*

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

Pathogen testing performed:

89. Was **CSF** tested for **enteroviruses?**	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:
	If test result was positive, was typing performed? ☐yes ☐no ☐unknown
	If yes, method and result:
90. Was **CSF** tested specifically for **polioviruses?**	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:
91. Was **CSF** tested for **West Nile virus**?	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:
92. Was **CSF** tested for **St. Louis encephalitis virus**?	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:
93. Was **CSF** tested for **La Crosse virus**?	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:
94. If **CSF** testing **identified any pathogen,** describe:	Date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:

95. Was a **respiratory tract specimen** tested for **enteroviruses?**	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of specimen:
	Type of testing:
	Result/interpretation:
	If test result was positive, was typing performed? ☐yes ☐no ☐unknown
	If yes, method and result:

96. Was **a stool specimen** tested for **enteroviruses?**	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of specimen: ☐rectal swab ☐ whole stool ☐unknown
	Type of testing:
	Result/interpretation:
	If test result was positive, was typing performed? ☐yes ☐no ☐unknown
	If yes, method and result:

97. Was **stool** tested specifically for **polioviruses**?	☐yes ☐no ☐unknown If yes, date of **1st specimen** collection __ __/__ __/__ __ __ __
	Type of specimen: ☐rectal swab ☐ whole stool ☐unknown
	Type of testing:
	Result/interpretation:
	date of **2nd specimen** collection (if tested) __ __/__ __/__ __ __ __
	Type of specimen: ☐rectal swab ☐ whole stool ☐unknown
	Type of testing:
	Result/interpretation:

98. Was **serum** tested for: **West Nile virus?**	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:
99. St. Louis encephalitis virus?	☐yes ☐no ☐ unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:
100. La Crosse virus?	☐yes ☐no ☐unknown If yes, date of specimen collection __ __/__ __/__ __ __ __
	Type of testing:
	Result/interpretation:

101. Describe any other laboratory finding(s) considered to be significant_____

_____

102. Was/Is a **specific etiology** considered to be the most likely cause for the patient's neurological illness? ☐yes ☐no ☐unknown

103. If yes, please list etiology and reason(s) considered most likely cause _____

_____

104. Other information you would like us to know _____

_____

_____

105. Indicate which type(s) of specimens from the patient are **currently stored**, and could be available for possible additional testing at CDC:

☐ CSF ☐ Nasal wash/aspirate ☐BAL spec ☐Tracheal aspirate ☐NP/OP swab ☐Stool ☐Serum ☐ Other, list _____

☐ No specimens stored