

Acute Flaccid Myelitis: Patient Summary Form

Case Report Instructions

1. Complete Acute Flaccid Myelitis Patient Summary Form **AND** submit with the following medical records to the patient's local health jurisdiction:
 - a. Spinal and brain MRI reports
 - b. EMG reports (if applicable)
 - c. Lumbar puncture results
 - d. Pathogen testing reports (for CSF, respiratory tract, stool and serum specimens)
 - i. Include the following results (if applicable): enterovirus/rhinovirus, West Nile virus, poliovirus, herpes simplex virus, cytomegalovirus, varicella zoster virus, adenovirus, influenza virus, and other results
2. For specimen testing approval, contact Shrimati Datta (Shrimati.Datta@cdph.ca.gov; (510) 620-3747) or Kristen Wendorf (Kristen.Wendorf@cdph.ca.gov; (510) 307-8567)
3. After approval has been received, submit specimens to the California Department of Public Health
 - a. Send the following specimens (for more details on specimens and shipping instructions see the [AFM Quick Sheet](#)):
 - i. Nasopharynx, nasal swab, oropharyngeal or endotracheal aspirate
 - ii. CSF
 - iii. Acute and convalescent phase serum
 - iv. Two Stool specimens or rectal swabs collected 24 hours apart
 - b. Complete the [AFM Specimen Submittal Form](#) and mail specimens on cold packs for M-F delivery to:

ATTN: Specimen Receiving
Viral and Rickettsial Disease Laboratory
850 Marina Bay Parkway
Richmond, CA 94804

Case Criteria

- A. Does patient have acute focal limb weakness Yes No
- B. Was an MRI done? Yes No MRI scanner strength ≤ 1.5 Tesla 3.0 Tesla
If yes, does MRI show spinal cord lesion largely restricted to gray matter*, spanning one or more spinal segments? Yes No
- C. Does CSF show pleocytosis (white blood cell count > 5 cells/mm³)? Yes No

* 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. If still unsure if this criterion is met, consider consulting the neurologist or radiologist directly.

State assigned patient ID: _____

Patient Information

Last Name _____ First Name _____ Date of birth ____/____/____
Street Address _____ City _____ Zip Code _____ County _____

Reporting Information

Name of person completing form: _____
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: _____
Patient Medical Record # _____

Was/Is a **specific etiology** considered to be the most likely cause for the patient's neurological illness? Yes No Unknown

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

Acute Flaccid Myelitis: Patient Summary Form

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)
13. Did the patient die from this illness? yes no unknown 14. If yes, date of death ___/___/___

Signs/symptoms/condition at ANY time during the illness:

	Right Arm	Left Arm	Right Leg	Left Leg	
15. Since neurologic illness onset, which limbs have been acutely weak? [indicate yes(y), no (n), unknown (u) for each limb]	Y N U	Y N U	Y N U	Y N U	
16. Date of neurologic exam (recorded at most severe weakness to that point) (mm/dd/yyyy)	___/___/___				
17. Reflexes in the affected limb(s): (recorded at most severe weakness to that point)	<input type="checkbox"/> Areflexic/hyporeflexic (0-1) <input type="checkbox"/> Normal (2) <input type="checkbox"/> Hyperreflexic (3-4+)				
18. Any sensory loss/numbness in the affected limb(s), at any time during the illness? (paresthesias should not be considered here)	Y N U				
19. Any pain or burning in the affected limb(s)? (at any time during illness)	Y N U				
			Yes	No	Unknown
20. Sensory level on the torso (i.e., reduced sensation below a certain level of the torso)? (at any time during illness)					
If yes, specify:					
21. At any time during the illness, please check if the patient had any of the following cranial nerve features:					
<input type="checkbox"/> Diplopia/double vision (If yes, circle the cranial nerve involved if known: 3 / 4 / 6)					
<input type="checkbox"/> Loss of sensation in face <input type="checkbox"/> Facial droop <input type="checkbox"/> Hearing loss <input type="checkbox"/> Dysphagia <input type="checkbox"/> Dysarthria					
22. Bowel or bladder incontinence? (at any time during illness)					
23. Change in mental status (e.g., confused, lethargic, disoriented, encephalopathic)? (at any time during illness)					
If yes, specify:					
24. Seizure(s)? (at any time during illness)					
25. Received invasive ventilatory support because of neurological condition?					
<input type="checkbox"/> intubation <input type="checkbox"/> tracheostomy <input type="checkbox"/> Other Specify:					
Please check if patient had any of the following symptoms:					
<input type="checkbox"/> Rash	<input type="checkbox"/> Aphasia or mutism	<input type="checkbox"/> Ataxia	<input type="checkbox"/> Other Specify:		
<input type="checkbox"/> Headache	<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Autonomic Instability			

Other patient information:

Within the 4-week period BEFORE onset of limb weakness, did patient:	Yes	No	Unknown
26. Have a respiratory illness? 27. If yes, onset date ___/___/___			
Have a gastrointestinal illness? If yes, onset date ___/___/___			
28. Have a fever, measured by parent/provider & ≥ 38.0°C /100.4°F? 29. If yes, onset date ___/___/___			
In the 48 hours before onset of limb weakness, did patient have a fever?			
30. Receive any immunosuppressing agent(s)?			
31. If yes, list:			
32. Travel outside the county of residence, state or country?			
33. If yes, list locations and dates:			
34. Does patient have any underlying illnesses?			
35. If yes, list:			
Any other notable exposures? (head trauma, sick contacts, animal, outdoor, etc)			
If yes, list:			

Vaccination history:

Are immunizations up to date?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
How many documented doses of Polio vaccine?	IPV doses:	OPV doses:	Number of doses (unknown type):