Georgia Department of Public Health Acute Flaccid Myelitis (AFM) Case Report Form

SendSS ID: _____

Form Complete □ Yes □ No

PATIENT DEMOGRAPHICS

Patient name: Last, First M.I.	Date of birth: ____/____/____	Age *(enter age and check one):* ____ □ Days □ Weeks □ Mos □ Yrs	Gender: □ M □ F □ Other □ Unknown
Street Address:	City:	State: ZIP code:	County:
Telephone no.: Home ( ) –	Work ( ) –	Cell ( ) –	SSN - -

Ethnicity (check one):
□ Hispanic/Latino
□ Non-Hispanic/Latino
□ Unknown

Race (check all that apply):
□ Black/African-American
□ Native American/Alaskan Native
□ White
□ Asian /Pacific Islander
□ Multiracial
□ Other (please specify)_____
□ Unknown

Died: □ Yes □ No □ Unknown

Date of Death:(mm/dd/yy) ____/____/____

TRACKING DATA

Medical record no. or client no.:

State Case ID ***(For state use only):***

Date reported to health department: ____/____/____	Date investigation started: ____/____/____	Person reporting:	Reporter telephone: ( ) –
Case investigator completing form:	Organization:	Investigator phone: ( ) –	

Event Date: ____/____/____

Event Type: □ Weakness Onset Date □ Diagnosis Date □ Lab Test Date □ Unknown □ Report Date (County) □ Report Date (State)

Note: Supplemental materials requested with submission of case report form: (call Public Health for submission instructions)

□ MRI Report □ MRI Images

ATTENDING PHYSICIAN

Name:	Main hospital that provided Patient's care:
Phone: ( ) –	Name of Contact at hospital:

HOSPITAL ADMISSIONS

Was the patient hospitalized? □ Yes □ No □ Unknown *If yes, complete the questions below for each hospital:*

Facility (list most recent)	Admission Date:	Discharge Date:	Admitted to ICU?	If Yes, ICU Admit date:
_____	____/____/____	____/____/____	□ Y □ N □ U	____/____/____
_____	____/____/____	____/____/____	□ Y □ N □ U	____/____/____
_____	____/____/____	____/____/____	□ Y □ N □ U	____/____/____

SIGNS AND SYMPTOMS

Date of onset of limb weakness: (mm/dd/yy) ____/____/____

Weakness? (indicate yes, no, unknown **for each limb**)		Specify the tone **in each limb**. (select ALL that apply)	
Right Arm	□ Yes □ No □ Unknown	□ Flaccid □ Spastic	□ Normal □ Unknown
Left Arm	□ Yes □ No □ Unknown	□ Flaccid □ Spastic	□ Normal □ Unknown
Right Leg	□ Yes □ No □ Unknown	□ Flaccid □ Spastic	□ Normal □ Unknown
Left Leg	□ Yes □ No □ Unknown	□ Flaccid □ Spastic	□ Normal □ Unknown

Any co-morbid medical conditions? □ Yes □ No □ Unknown	Is the patient immunocompromised? □ Yes □ No □ Unknown	IVIG received during course of illness? □ Yes □ No □ Unknown
If yes, specify conditions: _____	If yes, list immunocompromising medications, _____	If yes, specify 1st date treatment was received: ____/____/____

In the 4-weeks BEFORE onset of limb weakness, did patient:

Have respiratory illness?: □ Yes □ No □ Unknown If yes, onset date: ____/____/____	Have a gastrointestinal illness?: □ Yes □ No □ Unknown If yes, onset date (mm/dd/yy): ____/____/____
Have a Fever? □ Y □ N □ U	If yes, highest recorded temp.: _____°F & Total # of days with fever: _____
Have pain in neck or back? □ Yes □ No □ Unknown	If yes, onset date (mm/dd/yy): ____/____/____

Please fax completed form to your District Health Department

Updated Feb-20

AFM Case Report Form Contd.-GDPH

LABORATORY TESTS

Was rhinovirus and/or enterovirus testing done at hospital or reference laboratory? □ Yes □ No □ Unknown

Specimen Type	Result	Date Specimen Collected:	Lab Name:	Comments:
NP swab	_____	____/____/____	_____	_____
OP swab	_____	____/____/____	_____	_____
CSF	_____	____/____/____	_____	_____
Unknown	_____	____/____/____	_____	_____

Result Codes: P:Positive X:Not done N:Negative I:Indeterminate E:Pending U:Unknown

MRI Information/CSF Examination

Was an MRI of the spinal cord performed: □ Y □ N □ U If yes, Date performed ___/___/___

If performed, did the spinal MRI show a lesion in at least some spinal cord grey matter? □ Y□ N □ U

Was an MRI of the brain performed: □ Y□ N □ U If yes, Date performed ___/___/___

Was a lumbar puncture (LP) performed? □ Y □ N □ U

If yes, complete the questions below:

	LP1	LP2
Date Performed	____/____/____	____/____/____
WBC/mm^3	_____	_____
% neutrophils	_____	_____
% lymphocytes	_____	_____
% monocytes	_____	_____
% eosinophils	_____	_____
RBC/mm^3	_____	_____
Glucose mg/dl	_____	_____
Protein mg/dl	_____	_____

Additional Patient Information

Is the patient:

Pregnant? □ Y□ N □ U

If Yes, weeks pregnant: _____

Healthcare worker? □ Y□ N □ U

□ Yes, w/o direct patient contact

□ Yes, with direct patient contact

Employed at or attend daycare? □ Y□ N □ U

Employed at or attend school? □ Y□ N □ U

Incarcerated? □ Y□ N □ U

Institutionalized? □ Y□ N □ U

(nursing home or chronic care facility)

EPIDEMIOLOGIC INFORMATION

Epi-linked to another confirmed or probable case? □ Yes □ No □ Unknown

If yes, name of epi-linked case: _____

SendSS ID of epi-linked case: _____

Was case 1st reported via Syndrome Surveillance Notification?

□Yes □No □Unknown

Relationship to case:

□ Mother □ Brother □ Grandparent □ Cousin □ Sibling N/S

□ Father □ Neighbor □ Friend □ Aunt □ Unknown

□ Sister □ Daycare □ Baby Sitter □ Uncle

□ Other _____

Outbreak of cluster related?

□ Yes □ No □ Unknown

Outbreak or cluster name:

_____

TRAVEL HISTORY

Did patient travel internationally within 30 days of symptom onset: □ Yes □ No □ Unknown

If Yes, please specify countries and dates of travel below (use Notes to indicate multiple destinations for a date range):

Country	Travel Start Date:	Travel End Date:	Notes/Additional Destinations:
_____	____/____/____	____/____/____	_____
_____	____/____/____	____/____/____	_____

Is this illness travel related? □ Yes □ No □ Unknown Notes: _____

SPECIMEN SUBMISSION TO CDC (*FOR STATE USE ONLY*): Were specimens submitted to GPHL for forwarding to CDC? □ Y □ N □ U

If yes, add specimen submission information below

Specimen Type	Collection Date:	Date shipped to GPHL:	Date forwarded to CDC:	Result:
CSF	____/____/____	____/____/____	____/____/____	_____
Serum	____/____/____	____/____/____	____/____/____	_____
NP/OP Swab	____/____/____	____/____/____	____/____/____	_____
Stool 1	____/____/____	____/____/____	____/____/____	_____
Stool 2	____/____/____	____/____/____	____/____/____	_____

State use only Supplemental Materials Submitted to CDC *(check all that apply):*

Materials	Date Submitted	Materials	Date Submitted
□ MRI Report	____/____/____	□ MRI Images	____/____/____

Comments:

Please fax completed form to your District Health Department