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

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)

□ History and physical □ MRI Report □ MRI Images □ Infectious disease consult notes
□ Neurology consult notes □ EMG report (if done) □ Vaccination record □ Diagnostic laboratory reports

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**) — If yes, specify the tone in affected limb(s) (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 GI illness?: □ Yes □ No □ Unknown If yes, onset date (mm/dd ____/____/____
Have a Fever? □ Y □ N □ U	If yes, highest recorded temp.: _____°F & Total # of days with fever: _____

LABORATORY TESTS

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

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

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

Please fax completed form to your District Health Department

MRI Information/CSF Examination

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

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 □ Other _____
□ Father □ Neighbor □ Friend □ Aunt □ Unknown
□ Sister □ Daycare □ Baby Sitter □ Uncle

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 llness travel related? □ Yes □ No □ Unknown Notes: _____

LONG TERM FOLLOW-UP: COMPLETE AT LEAST 60 DAYS AFTER ONSET OF LIMB WEAKNESS

Date of 60-days follow-up (mm/dd/yy):
____/____/____

Sites of Paralysis: □ Spinal □ Bulbar □ Spino-bulbar
Specific Sites:

60-day Residual:
□ None □ Minor (any minor involvement) □ Death
□ Significant (<2 extremities, major involvement) □ Unk
□ Severe (≥ 3 extremities & respiratory involvement)

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
□ History and physical	____/____/____	□ Infectious disease consult notes	____/____/____
□ MRI Report	____/____/____	□ Vaccination record	____/____/____
□ MRI Images	____/____/____	□ Diagnostic laboratory reports	____/____/____
□ Neurology consult notes	____/____/____		
□ EMG report (if done)	____/____/____		

Comments:

Created November 2018

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