January 2023

Instructions for Michigan Clinical Laboratories, Providers, and Local Health Departments Requesting Enterovirus Testing for Patients with Neurological Presentations

Please use the attached **CDC Patient Summary Form for Acute Flaccid Myelitis** to collect demographic, epidemiologic, and clinical information on patients with neurological presentations that you wish to have tested for enterovirus. All specimens must be approved by a subject matter expert (SME) at the Michigan Department of Health & Human Services (MDHHS) Communicable Disease Division **1-517-335-8165** prior to submission of the specimen(s) to the MDHHS Bureau of Laboratories (BOL). **The completed CDC Patient Summary Form with intact cover sheet (with patient identifiers below) should be faxed to the MDHHS Communicable Disease Division at 1-517-335-8263.** After approval for testing by a MDHHS SME, specimens may be submitted to the MDHHS BOL with a completed MDHHS BOL and CDC lab requisition forms; they may then be shipped to CDC. Links to the requisition forms are given below.

(This cover sheet with patient identifiers will be removed by MDHHS BOL before sending the Patient Summary Form to the CDC.)

Patient Information:

First name _____ Last name _____

Date of birth ____/____/____ Age _____ Sex ☐ Female ☐ Male

Street address_____ City_____ County _____

Hospital ID number_____ State ID number _____
(MDHHS use)

For MDHHS BOL and CDC requisition forms:
https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5103_5278-14806--,00.html

For additional information about Acute Flaccid Myelitis:
https://www.cdc.gov/acute-flaccid-myelitis/about-afm.html

PROVIDERS: DO NOT TEAR OFF THIS COVER SHEET – KEEP ATTACHED TO THE CDC PATIENT SUMMARY FORM when you fax to MDHHS Communicable Disease Division at 517-335-8263

MDHHS
Michigan Department of Health & Human Services

Public reporting burden of this collection of information is estimated to average 12 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.

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 AFMInfo@cdc.gov if sending to CDC***----------

Acute Flaccid Myelitis: Patient Summary Form

Form Approved
OMB No. 0920-0009
Exp Date: 01/31/2026

Please send the following information along with the patient summary form: ☐ *MRI report* ☐ *MRI images* ☐ Neurology consult note

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 ☐Native Hawaiian or Other Pacific Islander ☐White *(check all that apply)* **8**. Ethnicity: ☐Hispanic or Latino ☐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***]	☐ flaccid ☐ spastic ☐ normal ☐ unknown			☐ flaccid ☐ spastic ☐ normal ☐ unknown			☐ flaccid ☐ spastic ☐ normal ☐ unknown			☐ flaccid ☐ spastic ☐ normal ☐ 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 ≥38.0°C/100.4°F?				**23**. If yes, onset date __ __/__ __/__ __ __ __
24. Have pain in neck or back?				**25**. If yes, onset date __ __/__ __/__ __ __ __
26. At onset of limb weakness, does patient have any underlying illnesses?				**27.** If yes, list:

Travel history:	
28. Did the patient travel outside of the US in the 30 days before the onset of limb weakness?	☐ yes ☐ no ☐ unknown
28a. If yes, list country/countries	

Polio vaccination history:	
29. Has the patient received polio vaccine?	☐ yes ☐ no ☐ unknown
29a. How many doses of **inactivated polio vaccine (IPV)** are **documented** to have been received by the patient before the onset of limb weakness?	_____doses ☐ unknown
29b. How many doses of **oral polio vaccine (OPV)** are **documented** to have been received by the patient before the onset of limb weakness?	_____doses ☐ unknown
29c. How many doses of **unknown type of polio vaccine** are **documented** to have been received by the patient before the onset of limb weakness?	_____doses ☐ unknown

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Magnetic Resonance Imaging:

30. Was MRI of spinal cord performed? ☐ yes ☐ no ☐ unknown **31.** If yes, date of spine MRI: __ __/__ __/__ __ __ __

32. Did the spinal MRI show a lesion in at least some spinal cord gray matter? ☐ yes ☐ no ☐ unknown

33. Was MRI of brain performed? ☐ yes ☐ no ☐ unknown **34.** If yes, date of brain MRI: __ __/__ __/__ __ __ __

CSF examination: 35. Was a lumbar puncture performed? ☐ yes ☐ no ☐ unknown

If yes, complete 35 (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
35a. CSF from LP1									
35b. CSF from LP2									

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