

January 2018

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 <input type="checkbox"/> Female <input type="checkbox"/> 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



Acute Flaccid Myelitis: Patient Summary Form

Form Approved
OMB No. 0920-0009
Exp Date: 06/30/2019

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: _____

Please send the following information along with the patient summary form (check information included):
 History and physical (H&P) MRI report MRI images Neurology consult notes EMG report (if done)
 Infectious disease consult notes (if available) Vaccination record Diagnostic laboratory reports

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 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 | | |
|---|--|--|--|---|----|-----|---|---|---|---|---|---|---|---|---|
| | | | | Y | N | U | Y | N | U | Y | N | U | Y | N | U |
| 15. Weakness? [indicate yes(y), no (n), unknown (u) for each limb] | | | | | | | | | | | | | | | |
| 15a. Tone in affected limb(s) [flaccid, spastic, normal for each limb] | | | | <input type="checkbox"/> flaccid <input type="checkbox"/> spastic <input type="checkbox"/> normal <input type="checkbox"/> unknown | | | <input type="checkbox"/> flaccid <input type="checkbox"/> spastic <input type="checkbox"/> normal <input type="checkbox"/> unknown | | | <input type="checkbox"/> flaccid <input type="checkbox"/> spastic <input type="checkbox"/> normal <input type="checkbox"/> unknown | | | <input type="checkbox"/> flaccid <input type="checkbox"/> spastic <input type="checkbox"/> normal <input type="checkbox"/> 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 $\geq 38.0^{\circ}\text{C}/100.4^{\circ}\text{F}$? | | | | | | | 23. If yes, onset date ___/___/_____ | | | | | | | | |
| 24. Travel outside the US? | | | | | | | 25. If yes, list country: | | | | | | | | |
| 26. At onset of limb weakness, does patient have any underlying illnesses? | | | | | | | 27. If yes, list: | | | | | | | | |

- Other patient information:**
 28. Was MRI of spinal cord performed? yes no unknown 29. If yes, date of spine MRI: ___/___/_____
 30. Was MRI of brain performed? yes no unknown 31. If yes, date of brain MRI: ___/___/_____

CSF examination: 32. Was a lumbar puncture performed? yes no unknown
 If yes, complete 32 (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 |
|--------------------------|-------------------------|---------------------|---------------|---------------|-------------|---------------|---------------------|---------------|---------------|
| 32a. CSF from LP1 | | | | | | | | | |
| 32b. CSF from LP2 | | | | | | | | | |

Public reporting burden of this collection of information is estimated to average 20 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.

Acute Flaccid Myelitis Outcome – 60-day follow-up (completed at least 60 days after onset of limb weakness)

33. Date of 60-day follow-up: ___/___/___ (mm/dd/yyyy)

34. Sites of Paralysis: Spinal Bulbar Spino-bulbar 35. Specific sites: _____

36. 60-day residual: None Minor (any minor involvement) Significant (≤ 2 extremities, major involvement)
 Severe (≥ 3 extremities and respiratory involvement) Death Unknown

37. Date of death: ___/___/___ (mm/dd/yyyy)

Acute Flaccid Myelitis case definition

(<http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/2017PS/2017PSFinal/17-ID-01.pdf>)

Clinical Criteria

An illness with onset of acute flaccid limb weakness

Laboratory Criteria

- Confirmatory Laboratory Evidence: a magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter*† and spanning one or more vertebral segments
- Supportive Laboratory Evidence: cerebrospinal fluid (CSF) with pleocytosis (white blood cell count >5 cells/mm³)

Case Classification

Confirmed:

- Clinically compatible case AND
- Confirmatory laboratory evidence: MRI showing spinal cord lesion largely restricted to gray matter*† and spanning one or more spinal segments

Probable:

- Clinically compatible case AND
- Supportive laboratory evidence: CSF showing pleocytosis (white blood cell count >5 cells/mm³).

* Spinal cord lesions may not be present on initial MRI; a negative or normal MRI performed within the first 72 hours after onset of limb weakness does not rule out AFM. MRI studies performed 72 hours or more after onset should also be reviewed if available.

† 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.

Comment

To provide consistency in case classification, review of case information and assignment of final case classification for all suspected AFM cases will be done by experts in national AFM surveillance. This is similar to the review required for final classification of paralytic polio cases.

Acute Flaccid Myelitis specimen collection information

(<https://www.cdc.gov/acute-flaccid-myelitis/hcp/instructions.html>)

Acute Flaccid Myelitis job aid

(<https://www.cdc.gov/acute-flaccid-myelitis/downloads/job-aid-for-clinicians.pdf>)