Acute Flaccid Paralysis/myelitis surveillance: Patient Summary Form

Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of main hospital that provided patient’s care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient details

**1.** Pt name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **2.** Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(dd/mm/yyyy)*

**3**. Gender:  Male  Female **4.** Hospital number:\_\_\_\_\_\_\_\_\_\_\_\_

**5.** NHS number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **6.** Patient Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.**  Ethnicity:  Asian/Asian British  Black/African/Caribbean/Black British  Mixed/Multiple ethnicity

White  Other ethnicity. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8.** Date of onset of limb weakness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **9.** Was patient admitted to a hospital?  Yes  no

**10.** Date of admission to first hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **11.** Date of discharge from last hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12.** Did the patient die from this illness?  Yes  No **13.** If yes, date of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14.** Vaccination status:  Fully vaccinated for age  Partially vaccinated  Unvaccinated  Unknown

Clinical features in acute episode:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Right Arm** | **Left Arm** | **Right Leg** | | **Left Leg** |
| **15.** Weakness? [indicate *for each limb*] | Yes No | Yes No | Yes No | | Yes No |
| **15a.** Tone in affected limb(s)  [*flaccid, spastic, normal for each limb*] | flaccid  spastic  normal | flaccid  spastic  normal | flaccid  spastic  normal | | flaccid  spastic  normal |
| **16.** Any respiratory symptoms on presentation? | Yes No | Details : | | | |
| **17.** Any other clinical presentation? | Details: | | | | |
| **18.** Was patient admitted to ICU? | Yes No | Date: | | | |
| **19.** Did patient require ventilatory support because of neurological condition? | | | | Yes  No | |

Factors reported in the 4 weeks BEFORE onset of weakness:

|  |  |  |
| --- | --- | --- |
| **20.** Had a respiratory illness? | Yes  No | Onset date: |
| **21.** Had a gastrointestinal illness (e.g., diarrhoea or vomiting)? | Yes  No | Onset date: |
| **22.** Had a rash? | Yes  No | Onset date: |
| **23.** Travel outside the UK? | Yes  No | Country: |
| **24.** Any underlying illnesses? | Yes  No | Describe: |

Investigations:

**25.** Was MRI of spinal cord performed?  Yes  No

**26.** Was MRI of brain performed?  Yes  No

**27.** Was CXR performed?  Yes  No

**28.** Was EMG performed?  Yes  No

Samples taken

|  |  |  |
| --- | --- | --- |
|  | **Date (s) of sample** | **Results** |
| **29.** Stool |  |  |
| **30.** Respiratory |  |  |
| **31.** CSF |  |  |
| **32.** Serology |  |  |

**33.** Any other clinical information you would like to provide:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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60-day follow-up (Complete if at least 60 days after onset of limb weakness)

**34.** Any residual paralysis at 60 days?  Yes  No

**35.** If yes, details (site(s) and severity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_