ACUTE FLACCID MYELITIS
SPECIMEN SUBMISSION FORM

SOUTH DAKOTA DEPARTMENT OF HEALTH

PATIENT INFORMATION

Patient Name: Last | First | MI

Birth date: MM/DD/YYYY | Age: | Age Units: | Sex: M or F | Today's Date: MM/DD/YYYY

Race (check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Pregnancy Status:

Residence: State | County

Case ID: State Assigned Patient ID

Clinical Diagnosis:

Date of Onset: MM/DD/YYYY

Was patient admitted to hospital? ☐ Yes ☐ No ☐ Unknown

Date of admission to **first** hospital: MM/DD/YYYY

Date of discharge from **last** hospital: MM/DD/YYYY (or ☐ still in hospital at time of form submission)

Fatal: Yes or No

Date of Death: MM/DD/YYYY

ORIGINAL SUBMITTER (Organization that originally submitted specimen for testing)

Name: (Laboratory Director or Designee)
Prefix | Last | First | MI | Suffix | Degree

Institution Name:

Street Address:
Line 1
Line 2
City | Zip Code
State | Country

Fax: Country Code | Area Code | Local Number | Institutional e-mail

Point of Contact: (Person to be contacted if there is a question regarding this order)
Prefix | Last | First | MI | Suffix | Degree

Phone: Country Code | Area Code | Local Number | POC e-mail

TRAVEL HISTORY

Travel: Yes or No | Dates of Travel: MM/DD/YYYY to MM/DD/YYYY

Foreign Travel: (Countries)

Foreign Residence: (Country)

United States Travel: (States)

United States Residence: (State)

Note: Additional states or countries of residence or travel should be entered in the Brief Clinical Summary field.

SPECIMEN INFORMATION

Specimen Collected Date: MM/DD/YYYY | Time: hh:mm:ss

Material submitted:

Specimen source (type):

Specimen source site:

Collection method:

Treatment of specimen:

Transport medium/Specimen preservative:

Specimen handling:

RELEVANT IMMUNIZATION HISTORY

Immunization(s) | Date received: MM/DD/YYYY

Comments:

Modified 10/22/2018

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PATIENT HISTORY

BRIEF CLINICAL SUMMARY (Include signs, symptoms, and underlying illnesses if known)

STATE OF ILLNESS

- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Acute
- ☐ Chronic
- ☐ Convalescent
- ☐ Recovered

TYPE OF INFECTION

- ☐ Upper respiratory
- ☐ Lower respiratory
- ☐ Cardiovascular
- ☐ Gastrointestinal
- ☐ Genital
- ☐ Urinary tract
- ☐ Other, specify
- ☐ Sepsis
- ☐ Central nervous system
- ☐ Skin/soft tissue
- ☐ Ocular
- ☐ Joint/bone
- ☐ Disseminated

THERAPEUTIC AGENT(S) DURING ILLNESS

	Agent:	Start date:	End date:
1.			
2.			
3.			
		MM/DD/YYYY	MM/DD/YYYY

SIGNS/SYMPTOMS/CONDITION

	Right Arm	Left Arm	Right Leg	Left Leg
Weakness? (yes, no, or unknown **for each limb**)	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown
Tone in affected limb(s) (flaccid, spastic, normal, or unknown **for each limb**)	☐ Flaccid ☐ Spastic ☐ Normal ☐ Unknown	☐ Flaccid ☐ Spastic ☐ Normal ☐ Unknown	☐ Flaccid ☐ Spastic ☐ Normal ☐ Unknown	☐ Flaccid ☐ Spastic ☐ Normal ☐ Unknown

Was patient admitted to ICU?	○ Yes ○ No ○ Unknown	If yes, admit date:	MM/DD/YYYY
In the 4 weeks BEFORE onset of limb weakness, did patient have a fever, measured by parent or provider ≥ 38.0°C/100.4°F?	○ Yes ○ No ○ Unknown	If yes, onset date:	MM/DD/YYYY
At onset of limb weakness, does patient have any underlying illnesses?	○ Yes ○ No ○ Unknown	If yes, admit date:	MM/DD/YYYY
Was MRI of spinal cord performed?	○ Yes ○ No ○ Unknown	If yes, date of spine MRI:	MM/DD/YYYY
Was MRI of brain performed?	○ Yes ○ No ○ Unknown	If yes, date of brain MRI:	MM/DD/YYYY

CFS EXAMINATION:

Was a lumbar puncture performed? ○ Yes ○ No ○ Unknown

If yes, complete CSF form below *(If more than 2 CSF examinations, list the first 2 performed)*

	Date of lumbar puncture	WBC/mm³	% neutrophils	% lymphocytes	% monocytes	% eosinophils	RBC/mm³	Glucose mg/dl	Protein mg/dl
CSF from LP1									
CSF from LP2									

EXPOSURE HISTORY

Exposure: _____ Date of Exposure: _____ MM/DD/YYYY

☐ **Animal** Type of Exposure: _____

Common name: _____

Scientific name: _____

☐ **Anthropod** Type of Exposure: _____

Common name: _____

Scientific name: _____

PREVIOUS LABORATORY REULTS (Or attach copy of test results or worksheet)

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 results

Modified 10/22/2018