Guillain-Barre Syndrome (GBS) Surveillance Case Report

Health Protection Agency
MinistryofHealth
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HPA-SUR-U000132-F-2019-1

CDPH Case ID:

Patient Information (Complete or place ☑ appropriately)

ID Card number: Date Of Birth: DD 1MM 1yyyy	Date of Consultation:
Patient Name:	Sex: D Male D Female Age:
Permanent Address:	Pregnant: D Yes (week of gestation): D No
Current Address:	Contact no:

Submitting physician (Required information)

Name:	**Date of form completion:** DD / MM / YYYY
Email:	**Hospital/ Medical Facility:**
Contact no: **Fax:**	**Signature:**

Primary care physician/ Physician/ Pediatrician/ Neurologist (Required information)

Name:	**Fax:**
Contact no:	**Signature:**

GBS Symptoms (Complete or place ☑ appropriately)

Date of first symptoms: DD / MM / YYYY

(Check all that apply)

D Acute onset of bilateral and relatively symmetric flaccid weakness/paralysis of the limbs with or without involvement of respiratory orcranial nerve-innervated muscles

D Decreased or absent deep tendon reflexes at least in affected limbs

D Electrophysical findings consistent with GBS

D Presence of cytoalbuminologic dissociation (elevation of CSF protein concentration above the laboratory normal, with CSF WBC <50 cells/mm3)

D Absence of an alternative diagnosis for weakness

Date of Hospital Admission: DD / MM / YYYY

Is/Was the patient hospitalized: DYes D No D Unknown

Is/Was the patient in the ICU: DYes D No D Unknown

If discharged, discharge date: DO / MM / YYYY

Discharge status: D Still at admitting hospital
D Discharged to home
D Discharge to another healthcare facility
D Death - Date: .D...QJ..NtM_LY.Y.Y.Y

Past Medical Histo

Has the patient ever been diagnosed with GBS before?
D Yes -Date of diagnosis:
No
Unknown
oo 1MM1YYYY

Imaging Studies (e.g: MRI, CT, etc.)

Results:	**Date:** DD / MM / YYYY	**Contact no:**

EMG Study Results

Results:	**Date:** DD / MM / YYYY	**Contact no:**
Reporting Laboratory technician:		**Signature:**

CSF 1 Results / F-CSF 2 Results

CSF 1 Results	F-CSF 2 Results
Date:	**Date:**
RBC:	**RBC:**
WBC:	**WBC:**
%Diff: (seg / lymp / mono / eos)	**%Diff:** (seg / lymp / mono / eos)
Protein: **Glucose:**	**Protein:** **Glucose:**

Symptoms of possible Infection that occurred within 6 weeks prior to onset of GBS-like syndrome? (Check all that apply)

D Fever(> 38·C) D Diarrhea D Nausea/Vomiting
D Upper respiratory (sora throat, rhinorrhea, congestion)
D Lower respiratory (cough, shortness of breath, wheezing)
D Rash D Headache D Suspected Dengue
D Arthalgias D Malaiselfatique D Suspected Chikungunya
D Myalgia& D Conjunctivial Hyperemia
D Non-purulent conjunctivitis
D Other- Specify:

other underlying medical conditions?
DYes D No D Unknown Other- Specify: .....

Campylobac:ter jejuni Test Results

Specimen Type:

Collection Date: DD / MM / YYYY

Reporting Laboratory technician: Signature:

Infection History (Complete or plac:e w1" appropriately)

Has the patient been diagnosed with *any* of the conditions below within 6 weeks prior to onset of GBS-like syndrome?
Dves D No D Unknown

Other- Specify:

D Influenza A Date:DD 1 MM 1YYYY D *Campylobacter* Date:DD I MM I YYYY
D Influenza B Date:DD 1 MM 1YYYY D CMV Date:DD I MM I YYYY
D H1N1Fiu Date:DDIMM/YYYY D EBV Date:DDIMMIYYYY
D Uknown Influenza Date:DD/MM/YYYY D Enterovirus Date:DD/MM/YYYY

Other microbiological studies/results

Data Entry and Quality Checks by HPA

Form Recieved by HPA: DD / MM / YYYY	**Data entry:**	☐ Yes ☐ No
Name:		
Signature	**Results entry:**	☐ Yes ☐ No

Brighton Criteria (Place ☑ appropriately)

Level of diagnostic certainty 1☐ 2☐ 3☐ 4☐

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