California Department of Public Health
Viral and Rickettsial Disease Laboratory
850 Marina Bay Parkway
Richmond, CA 94804

Date Form Completed: __/__/____
Case ID:_____

Guillain-Barré Syndrome (GBS) Surveillance Case Report

Patient Information:

Last Name: _____ **First Name:** _____ **DOB:** __/__/____ **Age:** _____ **MR #:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Phone: Home (___) _____ Work (___) _____

Sex: ☐ Male ☐ Female ☐ Unknown **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Race:** ☐ White ☐ Black ☐ Unknown ☐ Asian/ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other: _____

Currently pregnant …….. ☐ Yes ☐ No ☐ Unk *Week of gestation:* _____

Submitting physician (Mandatory):

Name: _____ **Facility:** _____

Pager/Phone: (___) _____ **Fax:** (___) _____ **Email:** _____

Physician [pediatrician or primary care provider] Contact Information (Mandatory):

Name: _____ **Pager/Phone:** (___) _____ **Fax:** (___) _____

GBS Symptoms: Date of first symptoms ___/___/_____

Check all that apply:

- ☐ Acute onset of bilateral and relatively symmetric flaccid weakness/paralysis of the limbs with or without involvement of respiratory or cranial nerve-innervated muscles.
- ☐ Decreased or absent deep tendon reflexes at least in affected limbs
- ☐ Electrophysical findings consistent with GBS
- ☐ Presence of cytoalbuminologic dissociation (elevation of CSF protein concentration above the laboratory normal, with CSF WBC <50 cells/mm^3)
- ☐ Absence of an alternative diagnosis for weakness

Hospital Admit Date ___/___/_____

Is the patient currently in the ICU? ☐ Yes ☐ No ☐ Unk

Hospital Discharge Date ___/___/_____

Discharge Status ☐ Discharged at home ☐ Discharged at another healthcare facility ☐ Death Date ___/___/_____

Imagine Studies (e.g. MRI, CT, etc.) Date: ___/___/_____

_____

EMG Study Results Date: ___/___/_____

_____

CSF 1 Results	CSF 2 Results
Date: ___/___/_____	Date: ___/___/_____
RBC: _____	RBC: _____
WBC: _____	WBC: _____
%Diff: _____ (seg / lymph / mono / eos)	%Diff: _____ (seg / lymph / mono / eos)
Protein: _____ Glucose: _____	Protein: _____ Glucose: _____

Campylobacter jejuni Test Results

Specimen Type	Collection Date	Result
_____	___/___/_____	_____
_____	___/___/_____	_____

Other Microbiological Studies/Results: _____

Vaccine Information: *(Please provide as much info as possible)*

Rec'd any vaccine in 8 wks prior to illness onset? ☐ Yes ☐ No ☐ Unk

If 'Yes':

☐ **Swine (pandemic H1N1) flu** Date: ___/___/_____ ☐ Exact Date ☐ Approx Date
How was vaccine given? ☐ Injection ☐ Nose spray ☐ Unknown
Geographical location where vaccine given: _____

☐ **Swine (pandemic H1N1) flu** Date: ___/___/_____ ☐ Exact Date ☐ Approx Date
How was vaccine given? ☐ Injection ☐ Nose spray ☐ Unknown
Geographical location where vaccine given: _____

☐ **Seasonal flu** Date: ___/___/_____ ☐ Exact Date ☐ Approx Date
How was vaccine given? ☐ Injection ☐ Nose spray ☐ Unknown
Geographical location where vaccine given: _____

☐ **Other vaccines (please list all)**

_____ Date: ___/___/_____
_____ Date: ___/___/_____
_____ Date: ___/___/_____
Geographical location where vaccine given: _____

Important: If possible, please attach vaccine record to this form or fax to 510-307-8599 as soon as available.

Infection History

Have you been diagnosed with any of the following this year?

If 'Yes', where? _____

Check all that apply:

☐ Flu A	Date: ___/___/_____	☐ Campylobacter	Date: ___/___/_____
☐ Flu B	Date: ___/___/_____	☐ CMV	Date: ___/___/_____
☐ Swine Flu	Date: ___/___/_____	☐ EBV	Date: ___/___/_____
☐ Unknown Flu	Date: ___/___/_____		

Past medical history:

Previous episode of GBS? ☐ Yes ☐ No ☐ Unk
Date: ___/___/_____

Other underlying medical conditions? ☐ Yes ☐ No ☐ Unk

Specify other conditions: _____

Hospital name: _____

FAX this form: (510) 307-8599 or MAIL to: CDPH VRDL–Guillain-Barré Syndrome Project, 850 Marina Bay Pkwy, Richmond CA 94804
For questions regarding testing or specimens, call Cynthia Jean Yen (510) 307-8606 or Shilpa Gavali Jani (510) 307-8608