GOBIERNO DE PUERTO RICO
Departamento de Salud

GUILLAIN-BARRÉ SYNDROME CASE REPORT FORM

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Today's date: _____/_____/_____ (Day / Month / Year)

Minimal information required (Sections I-VI)

Please fill out sections I-VI and report as soon as possible

I. Patient Data

Name of Patient: _____ (Last Name) _____ (First Name)

Sex: ☐ M ☐ F

Date of birth: _____/_____/_____ (Day / Month / Year)

If patient is a minor, name of parent or primary caregiver: _____ (Last Name) _____ (First Name)

Country of birth: .....

II. Home (physical) address

City: **Zip code:** __ __ __ __ __ - __ __ __ __

Tel: **Other Tel:**

III. Provider who reported this case

Name of Provider:

Tel: **Fax:** **NPI:**

Hospital Name & Mailing Address:

IV. Current presentation

Onset of neuro symptoms: _____/_____/_____ (Day / Month / Year)

First sought care: _____/_____/_____ (Day / Month / Year)

Specimen collection date: _____/_____/_____ (Day / Month / Year)

	Yes	No	Unk
Bilateral & flaccid weakness	☐	☐	☐
Decreased/absent reflexes	☐	☐	☐
Prior episodes of GBS	☐	☐	☐
Dysautonomia	☐	☐	☐
Ophtalmoparesis	☐	☐	☐
Ataxia	☐	☐	☐

	Yes	No	Unk
Facial weakness	☐	☐	☐
Dysphagia	☐	☐	☐
Dysarthria	☐	☐	☐
Shortness of breath	☐	☐	☐
Pregnant	☐	☐	☐

If yes, gestational week: .....

V. Antecedent conditions within the last 2 months

Onset of most recent antecedent illness: _____/_____/_____ (Day / Month / Year)

	Yes	No	Unk
Rash	☐	☐	☐
Conjunctivitis	☐	☐	☐
Arthralgia	☐	☐	☐
Cough	☐	☐	☐
Nasal congestion	☐	☐	☐
Sore throat	☐	☐	☐
Nausea/vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Fever	☐	☐	☐
Vaccination	☐	☐	☐

If yes, which type:.....

	Yes	No	Unk
Heavy Metals	☐	☐	☐
Non-ethanol alcohol	☐	☐	☐
Chemotherapy	☐	☐	☐
International travel	☐	☐	☐

If yes, where:.....

VI. Past Medical History

	Yes	No	Unk
HTN	☐	☐	☐
DM	☐	☐	☐
HIV	☐	☐	☐
Cancer*	☐	☐	☐

*within the last 6 months

If yes, organ of origin:.....

VII. Supplemental data

Please fill out if data available

Cerebrospinal Fluid

_____/_____/_____ (Day / Month / Year)

WBC (cells/cc) .....

RBC (cells/cc) .....

Protein (mg/dl) .....

Glucose (mg/dl) .....

IgG index .....

Oligoclonal bands .....

IgG synthesis .....

Serum Glucose (mg/dl) .....

Electrophysiological Studies

_____/_____/_____ (Day / Month / Year)

AIDP	☐	AMSAN	☐
AMAN	☐	Unexcitable	☐
Other	☐	Not GBS	☐
Normal	☐	Technically ch.	☐

Imaging

Brain _____/_____/_____ (Day / Month / Year)

Normal ☐ Abnormal ☐

Describe .....

Spine

Normal ☐ Abnormal (not GBS) ☐ Consistent with GBS ☐

Describe .....

VIII. Therapies (date initiated)

Steroids ☐ _____/_____/_____ (Day / Month / Year)

Mechanical ventilation ☐ _____/_____/_____ (Day / Month / Year)

IVIG ☐ _____/_____/_____ (Day / Month / Year)

Plasma exchange ☐ _____/_____/_____ (Day / Month / Year)

IX. Outcome

Hospitalized Yes ☐ No ☐

Nadir _____/_____/_____ (Day / Month / Year)

Discharge date or death _____/_____/_____ (Day / Month / Year)

Outcome: Home ☐ Rehab ☐ Death ☐ Other ☐ .....

Hughes Disability Score (0–6) ..... (Nadir) ..... (Discharge)

X. For laboratory use

Case number ☐☐☐☐☐☐

SAN ID ☐☐☐☐☐☐ **GCODE** ☐☐

Specimen #	Days post onset (DPO)	Type	Date Received
S1			____/____/____
S2			____/____/____
S3			____/____/____
S4			____/____/____

Instructions to fill the Guillain-Barré Syndrome (GBS) Surveillance Report Form

The health provider (neurologist/physiatrist) will complete in print lettering the GBS Surveillance Report Form and will request the laboratory test: **arboviral panel (dengue, chikungunya, and Zika).**.Laboratory will submit filled out form and serum sample following standing procedures for dengue testing. Additional samples (e.g., urine, saliva, and/or cerebrospinal fluid) can be submitted in addition to form and serum sample.

Fill out as much of sections I-VI and report case as soon as possible.

• Section I, II, and III:

The complete name and information of the patient is essential because many persons have similar names and information. Complete as instructed.

• Section IV:

Onset of symptoms: onset of neurological manifestations and not antecedent symptoms.

First sought care: for neurological manifestations and not antecedent events, please report first encounter with a healthcare provider (inpatient or outpatient).

GBS diagnosis: date of a diagnosis of GBS as rendered by a neurologist or physiatrist.

Signs and symptoms: Please check all manifestations noted until date of submission of case report form (present at any time during illness).

• Section V, VI:

Onset of most recent antecedent illness: date of symptom onset for most recent antecedent illness in previous two months

Please report any antecedent symptoms/conditions present at any point within two months of the onset of GBS.

Please fill out any information available at the time of report submission, but do not delay reporting in order to complete all sections from VII-IX. If possible, please make a copy of this form, complete additional information and submit at time of patient's discharge. Subsequent serum samples can be tested using the arboviral panel and an updated filled out form.

• Section VII:

Cerebrospinal fluid (CSF) date: please list date of spinal tap with CSF findings used for GBS diagnosis.

Electrophysiological studies: please list date of study used for GBS diagnosis.

AIDP: Acute Inflammatory demyelinating polyradiculoneuropathy.

AMAN: Acute motor axonal neuropathy.

AMSAN: Acute motor-sensory axonal neuropathy.

Unexcitable: Electrically unexcitable nerves.

Other: other findings possibly associated with GBS.

Not GBS: Abnormal findings but not associated with GBS.

Normal: only if findings are completely normal.

Technically ch.: Study performed but technical challenges impede interpretation of results.

Imaging: List date of the most prominent brain and/or spinal imaging finding. For Brain imaging, check if there are any normal or abnormal findings. For Spine, list if normal, abnormal but not GBS, or abnormal and consistent with GBS.

• Section VIII:

List start dates of specific therapies (IVIG: Intravenous Immunoglobulin).

• Section IX:

List whether the patient was hospitalized for GBS, the date of nadir (nadir = the point of most severe neurological deficit/weakness) and outcome (as documented no later than 3 months after GBS onset).

Hughes disability score:

0 = A healthy state; 1 = Minor symptoms and capable of running; 2 = Able to walk 10m or more without assistance but unable to run; 3 = Able to walk 10m across an open space with assistance; 4 = Bedridden or chair bound; 5 = Requiring assisted ventilation for at least part of the day; 6 = Dead.