



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: _____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	Last Name	First Name	Date of birth: ____/____/____ Day Month Year
If patient is a minor, name of parent or primary caregiver: _____		Country of birth: _____	
Last Name		First Name	

II. Home (physical) address	III. Provider who reported this case
City: _____ Zip code: _____ - _____	Name of Provider: _____
Tel: _____ Other Tel: _____	Tel: _____ Fax: _____ NPI: _____
	Hospital Name & Mailing Address: _____

IV. Current presentation		Yes No Unk	Yes No Unk
Onset of neuro symptoms: ____/____/____ Day Month Year	Bilateral & flaccid weakness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Facial weakness: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
First sought care: ____/____/____ Day Month Year	Decreased/absent reflexes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dysphagia: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Specimen collection date: ____/____/____ Day Month Year	Prior episodes of GBS	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dysarthria: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Dysautonomia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Shortness of breath: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Ophthalmoparesis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pregnant: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Ataxia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, gestational week: _____

V. Antecedent conditions within the last 2 months		VI. Past Medical History	
Onset of most recent antecedent illness: ____/____/____ Day Month Year	Yes No Unk	Yes No Unk	Yes No Unk
Rash: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Sore throat: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heavy Metals: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	HTN: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Conjunctivitis: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nausea/vomiting: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Non-ethanol alcohol: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	DM: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arthralgia: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diarrhea: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chemotherapy: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	HIV: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fever: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	International travel: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer*: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nasal congestion: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vaccination: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, where: _____	*within the last 6 months
If yes, which type: _____			If yes, organ of origin: _____

VII. Supplemental data		IX. Outcome	
Please fill out if data available		Hospitalized Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cerebrospinal Fluid	Electrophysiological Studies	Imaging	
Protein (mg/dl): ____/____/____ Day Month Year	____/____/____ Day Month Year	Brain: ____/____/____ Day Month Year	
Glucose (mg/dl): _____	AIDP <input type="checkbox"/> AMSAN <input type="checkbox"/>	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
IgG index: _____	AMAN <input type="checkbox"/> Unexcitable <input type="checkbox"/>	Describe: _____	
WBC (cells/cc): _____	Other <input type="checkbox"/> Not GBS <input type="checkbox"/>	Spine	
RBC (cells/cc): _____	Normal <input type="checkbox"/> Technically ch. <input type="checkbox"/>	Normal <input type="checkbox"/> Consistent with GBS <input type="checkbox"/>	
Serum Glucose (mg/dl)		Abnormal (not GBS) <input type="checkbox"/> Describe: _____	

VIII. Therapies (date initiated)	IX. Outcome
Steroids <input type="checkbox"/> ____/____/____ Day Month Year	Hospitalized Yes <input type="checkbox"/> No <input type="checkbox"/>
Mechanical ventilation <input type="checkbox"/> ____/____/____ Day Month Year	Nadir ____/____/____ Day Month Year
IVIG <input type="checkbox"/> ____/____/____ Day Month Year	Discharge date or death ____/____/____ Day Month Year
Plasma exchange <input type="checkbox"/> ____/____/____ Day Month Year	Outcome: Home <input type="checkbox"/> Rehab <input type="checkbox"/> Death <input type="checkbox"/>
	Other <input type="checkbox"/> _____
	Hughes Disability Score (0-6)
 Nadir Discharge

X. For laboratory use								
Case number	Specimen #	Days post onset (DPO)	Type	Date Received	Specimen #	Days post onset (DPO)	Type	Date Received
_____	S1	____/____/____	_____	____/____/____	S3	____/____/____	_____	____/____/____
SAN ID	GCODE	S2	_____	____/____/____	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.