California Department of Public Health
Guillain-Barré Syndrome Project
850 Marina Bay Parkway
Richmond, CA 94804

Guillain-Barré Syndrome (GBS) Surveillance Case Report

Patient Information: **CDPH Case ID:** __ - _____ (Assigned by CDPH; Leave blank)

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

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

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

Sex: ☐ Male ☐ Female (↑ Click on boxes to select)

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ Asian ☐ Hawaiian / Pacific Islander ☐ Black ☐ American Indian/Alaskan Native ☐ Unknown ☐ Other: _____

Currently pregnant .... ☐ Yes (week of gestation): ___ ☐ No ☐ Unk

Submitting physician (Required information) **Date form completed:** __/__/____

Name: _____ **Hospital/Medical Facility:** _____

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

Primary care physician / pediatrician contact information (Required information)

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/Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown

Is/Was the patient in the ICU? ☐ Yes ☐ No ☐ Unknown ☐ N/A

If discharged, discharge date ___/___/_______

Discharge status
- ☐ Still at admitting hospital
- ☐ Discharged to home
- ☐ Discharged to another healthcare facility
- ☐ Death - Date ___/___/_______

Imaging 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
________	___/___/_______	________
Specimen Type	Collection Date	Result

Other microbiological studies/results: ________

Past Medical History

Has the patient ever been diagnosed with GBS before?

☐ Yes - Date of diagnosis: ___/___/_______ ☐ No ☐ Unknown

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

- ☐ Fever (≥ 38°C) ☐ Diarrhea ☐ Nausea/Vomiting
- ☐ Upper respiratory (sore throat, rhinorrhea, congestion)
- ☐ Lower respiratory (cough, shortness of breath, wheezing)
- ☐ Other – Specify: ________

Other underlying medical conditions? ☐ Yes ☐ No ☐ Unknown

Specify: ________

Infection History

Has the patient been diagnosed with any of the conditions below **within 6 weeks** prior to onset of GBS-like syndrome?

(Check all that apply) ☐ Yes ☐ No ☐ Unknown

☐ Influenza A	Date: ___/___/_______	☐ *Campylobacter*	Date : ___/___/_______
☐ Influenza B	Date: ___/___/_______	☐ CMV	Date: ___/___/_______
☐ H1N1Flu	Date: ___/___/_______	☐ EBV	Date: ___/___/_______
☐ Unknown Influenza	Date: ___/___/_______	☐ Enterovirus	Date: ___/___/_______

If diagnosed, name of diagnosing facility? __________

RECENT Vaccine Information

Prior to GBS symptom onset, did the patient receive any vaccine? (Check all that apply)

☐ **Seasonal influenza** (2010-2011) Date: __/__/____ ☐ Exact Date ☐ Approx Date

How was vaccine given? ☐ Injection ☐ Nose spray ☐ Unknown

Geographical location where vaccine given: _________

☐ **Other vaccines** (Please list all with date and location of administration)

____

PAST Vaccine Information

During the 2009-2010 influenza season, did the patient receive these vaccines? (Check all that apply)

☐ **Pandemic H1N1 influenza** (Single antigen; 2009-2010) Date: __/__/____ ☐ Exact Date ☐ Approx Date

How was vaccine given? ☐ Injection ☐ Nose spray ☐ Unknown

Geographical location where vaccine given: _________

☐ **Seasonal influenza** (2009-2010) Date: __/__/____ ☐ Exact Date ☐ Approx Date

How was vaccine given? ☐ Injection ☐ Nose spray ☐ Unknown

Geographical location where vaccine given: _________

Important: Attach vaccine record to this form or fax to 916-440-5969.

FAX this form: (916) 440-5969 or MAIL to: CDPH Guillain-Barré Syndrome Project, 850 Marina Bay Pkwy, P Building, Second Floor, Richmond CA 94804
For questions regarding testing or specimens, e-mail GBSreport@cdph.ca.gov or call Jacqueline Chan (510) 620-3985