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Tennessee Department of Health

Guillain Barré Syndrome Case Report Form

Revised: 1/2011

Please fill out this form as completely as possible and send or fax to Central Office: Tennessee Department of Health, Communicable and Environmental Disease Services, 1st Floor, Cordell Hull Bldg., 425 5th Ave. North, Nashville, TN 37243, Phone: 615.741.7247 Fax: 615.741.3857

DEMOGRAPHICS

CASE ID#:_____

Name **Last:**_____ **First:**_____ **Middle:** _____ **DOB:** ____/____/____

Reported Age: _____ ○ Days ○ Months ○ Years **Sex:** ○ Male ○ Female ○ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Phone - Home: _____ **Work:** _____ **Cell:** _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic **Race:** ☐ American Indian / Alaskan ☐ Hawaiian / Pacific Islander ☐ Asian ☐ White ☐ Black / African American ☐ Other

INVESTIGATION SUMMARY

Investigator Name_____ **Jurisdiction**_____

INVESTIGATION

Investigation Start Date: _____/_____/_____

Investigation Status: ○ Open ○ Closed

Physician: _____

HOSPITAL

Was the patient hospitalized for this illness?

○ Yes (**Hospital:** _____) ○ No ○ Unknown

Admission:____/____/____ **Discharge Date:** ____/___/_____

Illness Onset Date: ____/____/____

ANTECEDENT EVENTS

List any vaccinations the patient received in the 6 weeks before onset:

Vaccine_____
Brand_____Lot_____
Date received_____

Vaccine_____
Brand_____Lot_____
Date received_____

Vaccine_____
Brand_____Lot_____
Date received_____

☐ None

List any acute illnesses the patient had in the 6 weeks before onset:

Illness_____
Date_____

Respiratory illness? ○ Yes ○ No
Date_____

Diarrheal illness? ○ Yes ○ No
Date_____

Stool Culture? ○ Yes ○ No
Date_____
Result_____

☐ None

CLINICAL INFORMATION

Did a physician diagnose GBS or AIDP? ○ Yes ○ No
Primary/Secondary Diagnoses_____
Was onset of paralysis or weakness acute? ○ Yes ○ No

LABORATORY

Was an EMG performed?
○ Yes ○ No
If yes, was it suggestive of AIDP, GBS, or a peripheral demyelinating process?
○ Yes ○ No
CSF protein above range (in absence of high CSF WBC count)?
○ Yes ○ No

Laboratory Contact Information:_____

CASE STATUS

○ **Probable**	○ **Suspect**	○ **Noncase**
(physician diagnosed)	(suspected for other reason)	

Please enter probable and suspect cases in NEDSS. If probable case-patients received any vaccination in the 6 weeks before onset of illness, complete and submit a VAERS report online at www.vaers.hhs.gov.