New Jersey Department of Health

GUILLAIN-BARRE SYNDROME REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race
☐White ☐American Indian ☐Unknown/Other
☐Black ☐Asian

Ethnicity
☐Hispanic ☐Unknown
☐Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	☐Yes ☐No ☐Unknown	☐Possible ☐Probable ☐Confirmed

Clinical: Muscular weakness: ☐ Yes ☐ No ☐Unknown

If yes, specify involved group of muscles: _____

Sensory loss: ☐ Yes ☐ No ☐Unknown

If yes, specify location: _____

Risk Factors:

Did patient in the past three weeks have:

Surgery: ☐ Yes ☐ No ☐Unknown

Immunization: ☐ Yes ☐ No ☐Unknown

Infection (ask specifically about campylobacteriosis): ☐ Yes ☐ No ☐Unknown

If yes, specify: _____

Laboratory Tests:

CSF examination date: ____ / ____ / ____

Protein: _____ WBC/mL: _____

CBC: date: ____ / ____ / ____ WBC: _____ HGB: _____

Erythrocytes: _____ HCT: _____ Sedimentation Rate: _____

Electrophysiologic studies: ☐ Not Done

If done, results show:

1) slowing nerve conduction with features of demyelination: ☐ Yes ☐ No and/or

2) axonal damage: ☐ Yes ☐ No

Other changes specify:

_____

Comments:

Name and Title of Person Submitting Report	Telephone Number