ICMR - NATIONAL INSTITUTE OF VIROLOGY PUNE

Specimen Referral Form for GBS

Patient Identification

Full name (First) ________________ (Middle) ________________ (Surname) ___________________

Age ___ ___ years **Gender** Male/ Female

Residential address ____________________________ **Contact** Phone/Mobile ______________

Present Illness Details

First symptom _________________ **Date of onset of first symptom** __/__/__(dd/mm/yy)

Date of admission (dd/mm/yy)_______________

Current symptoms (Tick all that applies**)**

- ☐ Progressive weakness or paralysis
- ☐ Involvement of two or more limbs
- ☐ Cranial nerve involvement
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Cough
- ☐ Throat pain
- ☐ Fever
- ☐ Rash
- ☐ Joint pain
- ☐ Altered sensorium
- ☐ Other; specify ___________

Current status (Tick all that applies**)**: Admitted in – Ward / ICU/ PICU/ On ventilation/ ___________

Treatment: on Plasmapheresis/ IV-Ig treatment / Neither ________________

Clinical Illness (Antecedent illness before GBS features)

Any Antecedent illness in the last 6 weeks - Yes / No; Details ______________

Acute Gastrointestinal symptoms ☐ Acute Respiratory illness symptoms ☐ Other ☐ ________________

Date of onset _ _ / _ _ / _ _ Date of consultation _ _ / _ _ / _ _ Date of hospitalization _ _ / _ _ / _ _

Travel history- places visited in the last 6 weeks _______ Duration _________ days Date __/__/__ to __/__/_

History of consuming food outside – Yes/ No **If Yes, Food** ______ **Stall / Place** _____ **Date** _ _ / _ _ / _ _

History of attending mass events - Yes/ No **If Yes, details Food** ____ **Place** _____ **Date** _ _ / _ _ / _ _

History of vaccination in the last 2 months: Yes/ No. **If yes,** name of vaccine/s _______ **Date** _ _ / _ _ / _ _

Comorbidities No/ Yes, Details ____________________________

History of any autoimmune diseases Yes / No; if yes specify __________________

Immunocompromised or currently on immunosuppressive therapy Yes / No; if yes specify ___________

Any family member having illness in the last 6 weeks No/ Yes, Details __________________________

Details of referring physician/Hospital

Specimens: Stool / Blood / Urine / Throat swab / CSF / _____ / ______ **Date** _ _ / _ _ / _ _

Name of the referring physician________________ Hospital_____________________________________

Contact Number: __________________________ e-mail ID : ___________________________________