ICMR - NATIONAL INSTITUTE OF VIROLOGY PUNE

Guillain-Barre Syndrome (GBS) **Specimen Referral Form**

Patient Identification

Case Type: Sporadic Case / Unusual Case / Case Cluster / Outbreak/ _____ **Case-Patient ID:** _____

Full name (First): _____ (Middle): _____ (Surname): _____

Age: _____ years **Gender:** Male/ Female Residential address: _____

State: _____ **District:** _____ Contact Phone/Mobile: _____

Present Illness Details

First symptom _____ **Date of onset** __ __/__ __/__ __ **Date of admission** __ __ / __ __ / __ __

- ☐ Progressive weakness/ fatigue/ paresis of limbs
- ☐ Cranial nerve involvements / deficits
- ☐ Diarrhea / loose stool / bloody stool
- ☐ Nausea/ anorexia / loss of appetite
- ☐ Vomiting
- ☐ Abdominal pain/ stomachache/ stomach cramps
- ☐ Cough / runny nose / blocked nose /
- ☐ Throat pain / sore throat / swallowing difficulty
- ☐ Involvement of two or more limbs
- ☐ Altered sensorium / drowsiness/ seizures
- ☐ Fever / feverish / chills / rigors / malaise
- ☐ Muscle pain/ myalgia/ myopathy/ bodyache
- ☐ Joint pain/ arthralgia / arthropathy arthritis
- ☐ Rash/ other skin eruptions / lesions
- ☐ Jaundice / Icterus
- ☐ Other; specify _____

Type of GBS case: Suspected / Confirmed / Other _____

Variant/s of GBS: AMAN / AMSAN / AIDP/ A-CIDP/ MFS / Other _____

Current status: Admitted in – Ward / ICU/ PICU/ On ventilation/ _____ Date: __ __ / __ __ / __ __

Treatment: on Plasmapheresis/ IV-Ig treatment / Steroids / Neither / Other _____ Date: __ __ / __ __ / __ __

Clinical Illness (Antecedent illness & events before GBS features)

Antecedent illness in the last 6 weeks – No / YES; Duration of illness ____ days Place of illness_____

Acute Gastrointestinal illness ☐ Acute Respiratory illness ☐ Acute febrile illness ☐ Other _____

Date of onset - _ _/ _ _/ _ _ Date of doctor consultation _ _ / _ _ / _ _ Date of hospital admission _ _ / _ _ / _ _

Comorbidities No/ Yes, Details (name/s) _____, Any continuing medicines _____

Autoimmune disease/s No/ Yes; if yes, specify disease_____, drugs _____

Immunocompromised or immunosuppressive therapy No/ Yes; if yes, specify _____

Travel history - The place/s visited in the last 6 weeks _____ Duration __ __ days Date __/__/__ to __/__/__

Consumption of food outside – No/ YES If Yes, Food type _____ Stall / Place/s _____ Date _ _ / _ _ / _ _

Attendance at mass events - No/ YES If Yes, details Food type _____ Place/s _____ Date _ _ / _ _ / _ _

Vaccination in the last 2 months - No/ YES If yes, name of vaccine/s _____ Date _ _ / _ _ / _ _

Family member with illness - No/ Yes, Symptom/s _____ Date _ _ / _ _ / _ _

Details of referring physician/Hospital

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

Physician: _____ **Hospital**: _____ **Lab Lead**: _____

Contact Number/Mobile: _____ **E-mail ID** for reporting: _____

Virus/es or other pathogens suspected: _____ Any other information/request: _____

Please share the filled SRF and discuss it with the Diagnostic Virology Group Lab Coordinator before dispatch.