

**GUILLAIN-BARRÉ SYNDROME INVESTIGATION**

| <b>INITIAL DIAGNOSIS</b>  |                                   |   |                                   |
|---|-----------------------------------|---|-----------------------------------|
| <b>Initial Diagnosis/Notification: Guillain-Barré Syndrome</b>  |                                   |   |                                   |
| Date of Notification: <i>DD/MM/YYYY</i>   |                                   | Date Investigation Started: <i>DD/MM/YYYY</i> |                                   |
| <b>PATIENT'S DEMOGRAPHICS</b>   |                                   |   |                                   |
| Patient's ID Type:<br><input type="radio"/> Driver's License <input type="radio"/> TRN <input type="radio"/> Passport <input type="radio"/> NIN |                                   | Patient's ID Number:                          |                                   |
| First Name:   |                                   | Middle Name(s):                               |                                   |
| Last Name:  |                                   | Pet Name(s):                                  |                                   |
| Sex Assigned at Birth: <input type="radio"/> Male <input type="radio"/> Female  |                                   | Medical Record Number:                        |                                   |
| Date of Birth: <i>DD/MM/YYYY</i>  |                                   | Age:  |                                   |
| Country of Residence:   |                                   | Parish (Jamaica):                             |                                   |
| House Number, Street Name:  |                                   |   |                                   |
| Landmark or directions to address:  |                                   | Community:                                    |                                   |
| Phone Number:   |                                   | Email Address:                                |                                   |
| Occupation:   |                                   |   |                                   |
| Name of Workplace/School:   |                                   |   |                                   |
| Address of School/Workplace:  |                                   |   |                                   |
| Phone Number:   |                                   | Email Address:                                |                                   |
| <b>NEXT OF KIN</b>  |                                   |   |                                   |
| First Name:   |                                   | Last Name:                                    |                                   |
| Phone number:   |                                   | Email address:                                |                                   |
| Address: Lot/ Street/Community/Parish:  |                                   |   |                                   |
| Relationship to the Patient:  |                                   |   |                                   |
| <input type="radio"/> Mother  | <input type="radio"/> Father      | <input type="radio"/> Uncle                   | <input type="radio"/> Grandfather |
| <input type="radio"/> Guardian  | <input type="radio"/> Brother     | <input type="radio"/> Aunt                    | <input type="radio"/> Cousin      |
| <input type="radio"/> Sister  | <input type="radio"/> Grandmother | <input type="radio"/> Other                   |                                   |
| <b>MOTHER'S INFORMATION (If not next of kin)</b>  |                                   |   |                                   |
| ID Type:<br><input type="radio"/> Driver's License <input type="radio"/> TRN <input type="radio"/> Passport <input type="radio"/> NIN           |                                   | ID Number:                                    |                                   |
| First Name:   |                                   | Middle Name(s):                               |                                   |
| Last Name:  |                                   | Pet Name(s):                                  |                                   |
| Maiden Name:  |                                   |   |                                   |
| House Number, Street Name:  |                                   | Parish (Jamaica):                             |                                   |
| Phone Number:   |                                   | Email Address:                                |                                   |
| <b>CLINICAL PROFILE</b>   |                                   |   |                                   |
| Date Patient Seen: <i>DD/MM/YYYY</i>  |                                   | Date of Home Visit: <i>DD/MM/YYYY</i>         |                                   |

| Sign or Symptom   | Presence                  |                          |                               | Date of Onset |
|---|---------------------------|--------------------------|-------------------------------|---------------|
| <b>Prodrome</b>   |                           |                          |                               |               |
| Fever   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| History of fever  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Respiratory involvement                                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Gastrointestinal involvement                            | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Fever   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Rash  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Sore throat   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Cough   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Shortness of breath                                     | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Diarrhoea   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Vomiting  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
|   |                           |                          |                               |               |
|   |                           |                          |                               |               |
| Rhinorrhoea   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Wheezing  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
|   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
|   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
|   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| <b>Associated Symptoms/Signs</b>                        |                           |                          |                               |               |
|   |                           |                          |                               |               |
| Muscle pain   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Meningeal signs   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Cranial pair involvement                                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Respiratory involvement                                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Fever at paralysis onset                                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Difficulty breathing (dyspnoea)                         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Dizziness / fainting (vertigo / syncope)                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Racing of heart (palpitation)                           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Nasal speech (dysphonia)                                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Difficulty speaking (dysarthria)                        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Changes in sweating                                     | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Difficulty keeping balance (ataxia)                     | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Urinary outflow problems                                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Diarrhoea   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Cardiac arrhythmia (tachycardia, bradycardia and other) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Pulmonary oedema  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Reduced chest expansion                                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Tachypnoea  | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Orthostatic hypotension                                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Blood pressure variability (from autonomic dysfunction) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |
| Eye movement abnormalities (external ophthalmoplegia)   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY    |

|   |                           |                          |                               |            |
|---|---------------------------|--------------------------|-------------------------------|------------|
| Difficulty articulating words (dysphonia) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY |
| Reduced/absent gag reflex                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY |
| Abnormalities in sensation                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY |
|   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY |
|   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY |
|   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY |
| <b>Paralysis</b>                          |                           |                          |                               |            |
| Paralysis                                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | DD/MM/YYYY |

Onset Duration of Paralysis: \_\_\_\_\_  month  day  week  hour  minutes

Paralysis Progression: Ascending Descending Other Nadir: DD/MM/YYYY

| Paralysis Findings Per Limb |  |  |   |   |
|-----------------------------|--|--|---|---|
| Limb                        | Presence of Paralysis  | Location of Paralysis  | Reflex detail   | Sensation   |
| Right arm                   | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <input type="radio"/> Proximal<br><input type="radio"/> Distal<br><input type="radio"/> Both | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown |
| Left arm                    | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <input type="radio"/> Proximal<br><input type="radio"/> Distal<br><input type="radio"/> Both | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown |
| Right leg                   | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <input type="radio"/> Proximal<br><input type="radio"/> Distal<br><input type="radio"/> Both | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown |
| Left leg                    | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <input type="radio"/> Proximal<br><input type="radio"/> Distal<br><input type="radio"/> Both | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown | <input type="radio"/> Increased<br><input type="radio"/> Normal<br><input type="radio"/> Decreased<br><input type="radio"/> Absent<br><input type="radio"/> Unknown |

| Lateralized specific symptom/sign                       |  |               |   |         |
|---|--|---------------|---|---------|
| Sign/Symptom  | Presence   | Date of Onset | Body Site   | Comment |
| Acroparesthesia (numbness, tingling of fingers or toes) | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | DD/MM/YYYY    | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |         |
| Radicular back pain (back pain radiating to legs)       | <input type="radio"/> Yes<br><input type="radio"/> No                                  | DD/MM/YYYY    | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |         |

|                                   |  |                   |   |  |
|-----------------------------------|--|-------------------|---|--|
|                                   | <input type="radio"/> Unknown  |                   |   |  |
| Weakness of legs                  | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <i>DD/MM/YYYY</i> | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |  |
| Weakness of arms                  | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <i>DD/MM/YYYY</i> | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |  |
| Dysphagia (difficulty swallowing) | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <i>DD/MM/YYYY</i> | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |  |
| Blurred vision                    | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <i>DD/MM/YYYY</i> | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |  |
| Hearing Loss                      | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <i>DD/MM/YYYY</i> | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |  |
| Facial weakness                   | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <i>DD/MM/YYYY</i> | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |  |
| Ptosis (drooping of eyes)         | <input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> Unknown | <i>DD/MM/YYYY</i> | <input type="radio"/> Left<br><input type="radio"/> Right<br><input type="radio"/> Both |  |

**Blood Pressure:** \_\_\_ **Systolic** \_\_\_ **Diastolic**      **Date Done:** *DD/MM/YYYY*

**Position:**  Sitting       Reclining       Lying

| Body Part            | Muscle Power   | Deep tendon reflex  | Muscle Tone  |
|----------------------|--|---|--|
| Right arm (proximal) | <input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance<br><input type="radio"/> Movement against at least some resistance supplied by the examiner | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |

| Body Part            | Muscle Power   | Deep tendon reflex  | Muscle Tone  |
|----------------------|--|---|--|
| Right arm (distal)   | <input type="radio"/> Full strength<br><input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance<br><input type="radio"/> Movement against at least some resistance supplied by the examiner<br><input type="radio"/> Full strength | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |
| Left arm (proximal)  | <input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance<br><input type="radio"/> Movement against at least some resistance supplied by the examiner<br><input type="radio"/> Full strength  | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |
| Left arm (distal)    | <input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance<br><input type="radio"/> Movement against at least some resistance supplied by the examiner<br><input type="radio"/> Full strength  | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |
| Right leg (proximal) | <input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance   | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |

| Body Part           | Muscle Power  | Deep tendon reflex  | Muscle Tone  |
|---------------------|---|---|--|
|                     | <input type="radio"/> Movement against at least some resistance supplied by the examiner<br><input type="radio"/> Full strength   |   |  |
| Right leg (distal)  | <input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance<br><input type="radio"/> Movement against at least some resistance supplied by the examiner<br><input type="radio"/> Full strength | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |
| Left leg (proximal) | <input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance<br><input type="radio"/> Movement against at least some resistance supplied by the examiner<br><input type="radio"/> Full strength | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |
| Left leg (distal)   | <input type="radio"/> No visible muscle contraction<br><input type="radio"/> Visible muscle contraction<br>With<br><input type="radio"/> No or trace movement<br><input type="radio"/> Limb movement, but not against gravity<br><input type="radio"/> Movement against gravity but not resistance<br><input type="radio"/> Movement against at least some resistance supplied by the examiner<br><input type="radio"/> Full strength | <input type="radio"/> Absent<br><input type="radio"/> Slight<br><input type="radio"/> Normal<br><input type="radio"/> Brisk<br><input type="radio"/> Non-sustained clonus<br><input type="radio"/> Sustained clonus | <input type="radio"/> Normal<br><input type="radio"/> Increased<br><input type="radio"/> Decreased |

|                           |                                  |  |
|---------------------------|----------------------------------|--|
| <b>VACCINATION STATUS</b> |                                  |  |
| Polio Vaccination:        | <input type="radio"/> Up to Date | <input type="radio"/> Up to Date for Age |
|                           |                                  | <input type="radio"/> Not up to Date     |



**DIAGNOSTIC INVESTIGATION SCREENING**

| CSF Test - Collection Details |                  |                         |                           | Specimen - Laboratory Details    |  |                          |  |
|-------------------------------|------------------|-------------------------|---------------------------|----------------------------------|--|--------------------------|--|
| Specimen Number               | Test Type        | Date Specimen Collected | Date Specimen Sent to Lab | Date/time received by laboratory | Adequacy for testing   | Quantitative Test result | Interpretative Test result   |
|                               | Protein          | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                               | RBC              | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                               | WBC              | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                               | WBC differential | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                               | Glucose          | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed  |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate  |

| CSF Test - Collection Details |           |                         |                           | Specimen - Laboratory Details    |   |                          |  |
|-------------------------------|-----------|-------------------------|---------------------------|----------------------------------|---|--------------------------|--|
| Specimen Number               | Test Type | Date Specimen Collected | Date Specimen Sent to Lab | Date/time received by laboratory | Adequacy for testing  | Quantitative Test result | Interpretative Test result   |
|                               |           |                         |                           |                                  | <input type="radio"/> Unsatisfactory-analysed<br><input type="radio"/> Unsatisfactory – not analysed  |                          | <input type="radio"/> Negative<br><input type="radio"/> Unknown  |
|                               | VDRL      | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory-analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                               |           | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory-analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                               |           | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory-analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                               |           | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory-analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |

| Blood Tests - Collection Details |               |                         |                           | Specimen - Laboratory Details    |  |                          |  |
|----------------------------------|---------------|-------------------------|---------------------------|----------------------------------|--|--------------------------|--|
| Specimen Number                  | Specimen Type | Date Specimen Collected | Date Specimen Sent to Lab | Date/time received by laboratory | Adequacy for testing   | Quantitative Test result | Test result  |
|                                  | HIV           | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                                  | HTLVI         | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                                  | B12           | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                                  | CPK           | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                                  | LDH           | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                                  | VDRL          | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                                  |               | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |

| Blood Tests - Collection Details |               |                         |                           | Specimen - Laboratory Details    |  |                          |  |
|----------------------------------|---------------|-------------------------|---------------------------|----------------------------------|--|--------------------------|--|
| Specimen Number                  | Specimen Type | Date Specimen Collected | Date Specimen Sent to Lab | Date/time received by laboratory | Adequacy for testing   | Quantitative Test result | Test result  |
|                                  |               | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |
|                                  |               | <i>DD/MM/YYYY</i>       | <i>DD/MM/YYYY</i>         | <i>DD/MM/YYYY</i>                | <input type="radio"/> Satisfactory - analysed<br><input type="radio"/> Unsatisfactory- analysed<br><input type="radio"/> Unsatisfactory – not analysed |                          | <input type="radio"/> Positive<br><input type="radio"/> Indeterminate<br><input type="radio"/> Negative<br><input type="radio"/> Unknown |

**Laboratory Comments:**



|   |                      |   |
|---|----------------------|---|
| Email Address:                            | Email Address:       |   |
| Name of Institution:                      | Name of Institution: |   |
| Community:                                | Community:           |   |
| Parish:                                   | Parish:              |   |
| Investigator's Office Number/Street Name: |                      |   |
| Investigator's Health Region:             |                      |   |
| Name of Parish MO(H):                     | Signature of MO(H):  | Date signed by MO(H): <i>DD/MM/YYYY</i> |