**New Jersey Department of Health**  
**GUILLAIN-BARRE SYNDROME REPORT**

<table>
<thead>
<tr>
<th>Name (Last)</th>
<th>(First)</th>
<th>(MI)</th>
<th>Sex</th>
<th>Date of Birth (Age)</th>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>County</th>
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<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone Number</th>
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**Race**  
- □ White  
- □ American Indian  
- □ Unknown/Other  
- □ Black  
- □ Asian  

**Ethnicity**  
- □ Hispanic  
- □ Non-Hispanic  
- □ Unknown  

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

**Hospital (Name, Address and Telephone No.)**

<table>
<thead>
<tr>
<th>Date of Diagnosis</th>
<th>Onset Date of Illness</th>
<th>Deceased?</th>
<th>Case Status</th>
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**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**