ACUTE FLACCID PARALYSIS
CASE INVESTIGATION FORM

(This form should be completed for all persons in which Acute Flaccid Paralysis is found and no specific cause can be immediately identified.)

IDENTIFICATION

CASE ID: _____ YEAR _____

COUNTRY _____ PROV/STATE _____ MUNICIP. LOCALE

Patient's Name _____ Mother's Name _____

Address _____ Urban: ❑ Rural ❑

Sex: Male ❑ Female ❑ Date of Birth: ____/____/____ Age: yrs _____ mos _____ No OPV Doses _____ Date Last dose ____/____/____

Date Investigated ____/____/____ Date Reported: Local ____/____/____ National ____/____/____ First Reported by: _____

OBSERVATIONS: _____

CLINICAL DATA

PRODROME

Fever : Yes ❑ No ❑ Unk.❑

Respiratory: Yes ❑ No ❑ Unk.❑

Diarrhea: Yes ❑ No ❑ Unk.❑

SIGNS

Muscle Pains: Yes ❑ No ❑ Unk.❑

Stiff Neck: Yes ❑ No ❑ Unk.❑

AT ONSET OF PARALYSIS

Date of Onset ____/____/____

Fever at Onset:

Yes ❑ No ❑ Unk.❑

PROGRESSION

Number of days for paralysis to fully develop:

Ascending ❑ Descending ❑

SITE OF FLACCID PARALYSIS				REFLEXES I/D/A/N/U*	SENSATION I/D/A/N/U*
RIGHT ARM	Yes ❑ No ❑ Unk.❑	Proximal ❑			
		Distal ❑			
LEFT ARM	Yes ❑ No ❑ Unk.❑	Proximal ❑			
		Distal ❑			
RIGHT LEG	Yes ❑ No ❑ Unk.❑	Proximal ❑			
		Distal ❑			
LEFT LEG	Yes ❑ No ❑ Unk.❑	Proximal ❑			
		Distal ❑			

*I=Increased D=Decreased A=Absent N=Normal U=Unknown

If Hospitalized? Name: _____ Date ___/___/___ Med. Rec # _____

Death? Yes ❑ No ❑ Unk.❑ If Yes, Date ___/___/___ Cause: _____

OBSERVATIONS: _____

LABORATORY DATA

CASE	How Stool Obtained	Submitting Laboratory	Date Stool Taken	Date Received Central Lab	Date Received Region Lab	Date Result Received	Results
Feces 1			____/____/____	____/____/____	____/____/____	____/____/____	
Feces 2			____/____/____	____/____/____	____/____/____	____/____/____	

CONTACTS *	Initials	Age	No. OPV Doses	Date of Last Dose	Date Stool Taken	Date Received Central Lab	Date Received Region Lab	Date Result Received	Results
Contacts 1				____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Contacts 1				____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Contacts 1				____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Contacts 1				____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Contacts 1				____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	

* Contacts should be < 5 yrs of age and not vaccinated within 30 days. List add'l contacts on separate page.

SPINAL TAP? ? Yes ❑ No ❑ Date: ____/____/____ Cells: _____ Protein: _____

OBSERVATIONS: _____

CONTROL

Date special control vaccination begun ___/___/___ Population <5 years _____ No. <5 years Vaccinated _____

Estimated number of house-holds in target Area _____ Number of house-holds visited _____

OBSERVATIONS: _____

FOLLOW-UP

Date Follow-up ___/___/___ Residual Paralysis at 60 days Yes __ No__ Unk __ Atrophy Yes __ No __ Unk __

FINAL DX: POLIO ❑ POLIO COMPATIBLE ❑ POLIO VACCINE ASSOC ❑ DISCARDED ❑ DATE CLASSIFIED ___/___/___

IF DISCARDED: GUILLAIN-BARRE ❑ TRAUMATIC NEURITIS ❑ TRANSVERSE MYELITIS ❑ TUMOR ❑ OTHER _____

OBSERVATIONS: _____

INVESTIGATOR

Name of Investigator _____ Signature _____

Title _____ Office: _____ Date ___/___/___

OBSERVATIONS: _____