

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 _____
YR _____ COUNTRY _____ PROV. / STATE _____ MUNICIPAL. _____ LOCALE _____	
Name _____ Mother's name _____	
Address _____ Urban _____ Rural _____	
Sex M ___ F ___ Date of birth: ___/___/___ Age: yrs. _____ mos. _____ No. OPV doses _____ Date last dose ___/___/___	
Date investigated: ___/___/___ Date reported: Local ___/___/___ National ___/___/___ First reported by: _____	
OBSERVATIONS:	

CLINICAL DATA <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>PRODROME</td> <td>Yes</td> <td>No</td> <td>Unk</td> </tr> <tr> <td>Fever</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td>Respiratory</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td>Diarrhea</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td>SIGNS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Muscle Pains</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td>Stiff Neck</td> <td>___</td> <td>___</td> <td>___</td> </tr> </table>	PRODROME	Yes	No	Unk	Fever	___	___	___	Respiratory	___	___	___	Diarrhea	___	___	___	SIGNS				Muscle Pains	___	___	___	Stiff Neck	___	___	___	AT ONSET OF PARALYSIS Date of onset ___/___/___ Yes No Unk Fever at onset _____ PROGRESSION Days for paralysis to fully develop: ___ days Ascending _____ Descending _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th rowspan="2"></th> <th colspan="3">SITE OF FLACCID PARALYSIS</th> <th colspan="2">REFLEXES</th> <th colspan="2">SENSATION</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>Unk</th> <th>I/D/A/N/U*</th> <th>I/D/A/N/U*</th> </tr> <tr> <td>RIGHT ARM</td> <td>___</td> <td>___</td> <td>___</td> <td>PROXIMAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>DISTAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td>LEFT ARM</td> <td>___</td> <td>___</td> <td>___</td> <td>PROXIMAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>DISTAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td>RIGHT LEG</td> <td>___</td> <td>___</td> <td>___</td> <td>PROXIMAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>DISTAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td>LEFT LEG</td> <td>___</td> <td>___</td> <td>___</td> <td>PROXIMAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>DISTAL</td> <td>___</td> <td>___</td> <td>___</td> </tr> </table>		SITE OF FLACCID PARALYSIS			REFLEXES		SENSATION		Yes	No	Unk	I/D/A/N/U*	I/D/A/N/U*	RIGHT ARM	___	___	___	PROXIMAL	___	___	___					DISTAL	___	___	___	LEFT ARM	___	___	___	PROXIMAL	___	___	___					DISTAL	___	___	___	RIGHT LEG	___	___	___	PROXIMAL	___	___	___					DISTAL	___	___	___	LEFT LEG	___	___	___	PROXIMAL	___	___	___					DISTAL	___	___	___
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If hospitalized: Hospital name _____ Date ___/___/___ Med. Rec. # _____																																																																																																											
Death: Yes ___ No ___ Unk ___ If yes: Date ___/___/___ Cause _____																																																																																																											
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*I = Increased, D = Decreased, A = Absent
N = Normal, U = Unknown

LABORATORY									
CASE	How stool obtained	Submitting laboratory	Date stool taken	Date received central lab	Date received regional lab	Date results 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 regional lab	Date results received	Results
CONTACT 1	___	___	___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___
CONTACT 2	___	___	___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___
CONTACT 3	___	___	___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___
CONTACT 4	___	___	___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___
CONTACT 5	___	___	___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___
*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 households in target area _____	Number of households visited _____	

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-BARRÉ ___ TRAUMATIC NEURITIS ___ TRANSVERSE MYELITIS ___ TUMOR ___ OTHER _____	

INVESTIGATOR		
Name of Investigator _____	Signature _____	
Title _____	Office _____	Date ___/___/___
OBSERVATIONS:		