Acute Flaccid Paralysis (AFP) Case Investigation Form

Country	Epidemiological or ID Case No.	Date of notification	Date of investigation
	/2_______	dd/mmm/yy	dd/mmm/yy

1. Identification

Patient's Name:

Age at time onset of paralysis/weakness (in months): ____________ Date of birth: dd/mmm/yy Sex: ☐Male ☐Female

Father's Name: Mother's Name:

Address: House No. ________________ Street: ________________ Village: ________________

Municipality/Town: ________________ City: ________________ County/Subdivision: ________________

Island/Province/Division: ________________

Contact number (1): ________________ Contact number (2): ________________

Does the child belong to migrant/mobile population/group: ☐Yes ☐No

If yes, please specify (seasonal migrants, economic migrants, high Risks): ________________

2. Notification

Notified by (name & designation): ________________ Name of health facility/unit (OPD): ________________

Is this health facility (check appropriate option):

☐ Active surveillance site (e.g., HBAS) ☐Passive/zero reporting site ☐ Community Informant

☐ Outside of surveillance network ☐Found during active search

Type of reporting site/health facility (check one appropriate option):

☐ Public ☐Private ☐Informal health care provider ☐ Community

3. Hospitalization

AFP case admitted in hospital facility: ☐Yes ☐No if yes, date of admission: dd/mmm/yy

Hospital facility name: ________________ Hospital ID #: ________________

Attending doctor's Name: ________________ If the patient died, date of death: dd/mmm/yy

4. Immunization History

Date of last OPV/IPV dose received: dd/mmm/yy

Total OPV/IPV doses received through Routine: ________________ Total OPV doses received through SIA/NID/SNID: ____________

History or vaccination record/card (if card, please write Card No.): ____________ Name of health centre: ________________

5. Travel History

☐ Yes ☐No If yes, place visited (please indicate administrative place accordingly):

Village	Town/City	Province	Division	Country	When and how long

Specify any prior history (check appropriate option):

☐ Headache ☐Seizures ☐Muscle pain ☐Polio vaccination ☐Fall/Injury ☐Intra-muscular injection (<30 days)

Please indicate site of injection (check appropriate option): ☐Buttock ☐ Antero-lateral thigh ☐Deltoid

Date of onset of paralysis: dd/mmm/yy Date of onset of symptoms: dd/mmm/yy

Number of days from onset to maximum paralysis?:_____ days ☐ Unknown

Is weakness/paralysis acute (sudden and rapid progression)?: ☐Yes ☐No

Is weakness/paralysis flaccid (i.e., floppy)?: ☐Yes ☐No

Was there fever at the onset of weakness/paralysis?: ☐ Yes ☐ No ☐Unknown

Is the weakness/paralysis asymmetric?: ☐ Yes ☐ No

Is the weakness/paralysis ascending?: ☐ Yes ☐ No

Other symptoms: ________________

7. Neurological Clinical Examination

Site of Paralysis (Please encircle appropriate option)

	Arm (Proximal)		Forearm (Distal)		Thigh (Proximal)		Leg (Distal)		Other Sites
	Right	Left	Right	Left	Right	Left	Right	Left	(Respiratory/ Cranial Nerves)
Muscle tone (Hyper/Hypo/Normal)									
Muscle power (0-5)									
Sensory loss (Yes/No)									
Deep tendon reflexes (0/+/++/+++)									
Meningeal signs									
Results of Clinical Diagnostic Test (CSF/X-Ray/CT scan/MRI/EMG-NCV/ Muscle Biopsy etc.)									

Does the patient have AFP?: ☐Yes ☐No

Are there any other AFP case(s) in the area where the AFP reside?: ☐Yes ☐No

Clinical working diagnosis:

Name of examining/investigating officer: ____________________ Place of investigation: ____________________ Signature: ____________________

8. Stool specimen collection, dispatch & receipt (VIDRL)

First stool specimen S1	Date of collection: dd/mmm/yy	Date sent to VIDRL: dd/mmm/yy	Date rec. at VIDRL: dd/mmm/yy
Second stool specimen S2 *(24 hours apart from S1)*	Date of collection: dd/mmm/yy	Date sent to VIDRL: dd/mmm/yy	Date rec. at VIDRL: dd/mmm/yy

Laboratory date results received: dd/mmm/yy Laboratory result 1: ____________________

Laboratory result 2: ____________________

9. Sixty (60) - Day Follow-Up Exam:

Please check: ☐In-person ☐phone ☐virtual ☐not done Date: dd/mmm/yy

If not done, reason:

Died?: ☐Yes ☐No If yes, date: dd/mmm/yy If yes, cause of death: ____________________

Residual paralysis present: ☐ Yes ☐No

Site of paralysis (check appropriate option): ☐Right arm ☐Left arm ☐Right leg ☐Left leg ☐Other sites (specify) __________

Ability to walk (check appropriate option): ☐Cannot walk ☐Walks with a limp (residual paralysis) ☐Walks normal

10. Final Classification: ☐ Confirmed polio ☐ Compatible ☐ Discarded

Name of Examiner: ____________________ Examiner's Signature: ____________________

Comments: (Please indicate if case is adequate or inadequate, write final clinical diagnosis based on history and 60 day follow up findings and correlate it with clinical diagnostic and stool laboratory results)