Investigation Form – POLIO (Modified: December 3, 2019)

Complete this form for any person aged <15 years with acute flaccid paralysis, and for a person of any age in whom polio is suspected.

I IDENTIFICATION

Case Number: _____

Country: _____

Province/State: _____

Municipality: _____

Locality/Neighborhood: _____

Detected by: ☐ 1=Spontaneous consultation 2=Laboratory 3=Institutional Search 4=Community Case Search 5=Contact investigation 6=Community Report 88=Other 99=Unknown

Health Service Name: _____

Health Service Telephone: _____

Reported by: _____

Date of Consultation: ____/____/____ (Day Month Year) Date Reported, Local: ____/____/____ (Day Month Year)

Date of Investigation: ____/____/____ (Day Month Year) *Date Reported, National* ____/____/____ (*Day Month Year*)

Type of provider reporting: ☐ 1=Public 2=Private 88=Other, Specify _____

II PATIENT INFORMATION

Patient's first and last name: _____ **Name of the mother or guardian:** _____ **Nationality** _____

Address: _____

Telephone: _____

Landmarks to locate the house: _____

Type of locality: ☐ 1=Urban 2=Periurban 3=Rural

Patient Occupation: _____

Work or School Address _____

Patient's Sex: ☐ 1=Male 2=Female Patient's date of birth: ____/____/____ (Day Month Year) If date of birth unavailable, age: _____ Years _____ Months

III VACCINATION HISTORY

Is vaccinated against Polio ☐ 1=Si 2=No 99=unknown

Type of Vaccine*	Number of doses**	Date of last dose (Day Month Year)	Source of vaccination Information †
		____/____/____	
		____/____/____	
		____/____/____	

(*) 1=OPV, 2=IPV, 99=Unknown
(**) 0=Zero dose, 1=One dose, 2=Two, 3=Three, etc., 99=Unknown
(†) 1=Vaccination card, 2=Health service record, 3=Verbal

IV CLINICAL DATA

PRODROME

Fever: ☐
Respiratory: ☐
Gastrointestinal: ☐
1=Yes 2=No 99=Unknown

PARALYSIS

Date of Onset: ____/____/____ (Day Month Year)

Fever at paralysis onset: ☐ 1=Yes 2=No 99=Unknown

Cranial pairs: ☐ 1=Yes 2=No
Respiratory: ☐ 99=Unknown

SITE OF FLACCID PARALYSIS

	1=Yes 2=No 99=Unknown	1=Proximal 2=Distal 3=Both	REFLEXES 1=Increased 2=Decreased 3=Absent 4=Normal 99=Unknown	SENSATION
Right arm	☐	☐	☐	☐
Left arm	☐	☐	☐	☐
Right leg	☐	☐	☐	☐
Left leg	☐	☐	☐	☐

SIGNS

Muscle pain: ☐
Meningeal: ☐
1=Yes 2=No 99=Unknown

PROGRESSION

Direction: ☐ 1=Ascending 2=Descending 3= Other

Number of days for paralysis to fully develop: _____

If hospitalized, hospital name: _____

Admission date: ____/____/____ (Day Month Year) Hospital Record. #: _____

Death?: ☐ 1=Yes 2=No 99=Unknown If Yes, Date: ____/____/____ (Day Month Year) Primary cause of death: _____

Comments: _____

V LABORATORY TESTING

Sample		Laboratory Test													
		Virus Isolation						Intratipic Differentiation (ITD)					Natl. vs Ref. discordance	Final result
Specimen #	Specimen obtained (Day/Month/Year)	Date sample sent to Lab. (Day/Month/Year)	**Name of Lab. processing the sample**	Date received (Day/Month/Year)	# Specimen ID in lab.	Result †	Date result (Day/Month/Year)	Date sent to Ref. Lab. (Day/Month/Year)	Ref. Lab. name	Date received by Ref. Lab. (Day/Month/Year)	Results ‡	Date ITD (Day/Month/Year)	1=Yes 2=No	§
	___/___/__	___/___/__	_____	___/___/__	_____	_____	___/___/__	___/___/__	_____	___/___/__	_____	__/___/__	_____	_____
	/___/__	/___/__	_____	___/___/__	_____	_____	___/___/__	/___/__	_____	___/___/__	_____	__/___/__	_____	_____

(†) 0=Negative, 4=Non Polio Enterovirus, 44= Poliovirus &NPEV, 5=Inadequate, 6=Other Virus, 77=Poliovirus

(‡) 1=P1Sabin, 2=P2Sabin, 3=P3Sabin, 5=Inadequate, 7=P1 Vacc. Derived, 8=P2 Vacc. Derived, 9=P3 Vacc. Derived, 10=P1 Wild, 11=P2 Wild, 12=P3 Wild

(§) Official Result

Comments: _____

Sample		Name	Age (YY/MM)	No. OPV Doses	Date of last dose
Contacts* (If necessary)	Contact 1	_____	_____	_____	____/____/____
	Contact 2	_____	_____	_____	____/____/____

* Contacts should be <5 years of age and not vaccinated within 30 days. List additional contacts on separate page.

	Laboratory Test													
		Virus Isolation						Intratypic Differentiation (ITD)					Natl. vs Ref. discordance	Final result
	Date taken (Day/Month/Year)	Date sample sent to Lab. (Day/Month/Year)	Lab. name	Date received (Day/Month/Year)	# specimen ID in lab.	Result †	Date Result (Day/Month/Year)	Date sent to Ref. Lab. (Day/Month/Year)	Name Ref. Lab.	Date received by Ref. Lab (Day/Month/Year)	Results ‡	Date ITD (Day/Month/Year)	1=Yes 2=No	§
	___/___/__	___/___/__	_____	___/___/__	_____	_____	___/___/__	___/___/__	_____	___/___/__	_____	__/___/__	_____	_____
	/___/__	/___/__	_____	___/___/__	_____	_____	___/___/__	/___/__	_____	___/___/__	_____	__/___/__	_____	_____

(†) 0=Negative, 4=Non Polio Enterovirus, 44= Poliovirus &NPEV, 5=Inadequate, 6=Other Virus, 77=Poliovirus

((‡) 1=P1Sabin, 2=P2Sabin, 3=P3Sabin, 5=Inadequate, 7=P1 Vacc. Derived, 8=P2 Vacc. Derived, 9=P3 Vacc. Derived, 10=P1 Wild, 11=P2 Wild, 12=P3 Wild

(§) Official Result

Comments: _____

VI FOLLOW-UP

Date of 60 days follow-up: ____/____/____ (Day Month Year)

Residual paralysis compatible with polio at 60 days: ☐ **1=Yes 2=No 99=Unknown**

Atrophy: ☐ **1=Yes 2=No 99=Unknown**

VII CONTROL

Date of mop-up vaccination begun: ____/____/____ (Day Month Year) Population <5 years: _____ Total <5 years vaccinated: _____

Estimated number of households in target area: _____ Number of households visited: _____

VIII CLASSIFICATION

FINAL CLASSIFICATION: ☐ **1=Confirmed Polio Wild** **2=Confirmed Polio Vacc. Derived** **3=Confirmed Polio Vacc. Associated** **4=Polio Compatible** **5=Discarded** Date classified: ____/____/____ (Day Month Year)	CLASSIFICATION CRITERIA: ☐ **1=Laboratory** **2=Lost to Follow Up** **3=Death** **4=With Residual Paralysis** **5=Without Residual Paralysis**	IF DISCARDED, DIAGNOSIS: ☐ **1=Guillain-Barré** **2=Traumatic Neuritis** **3=Transverse Myelitis** **4=Tumor** **99=Unknown** **88=Other** _____

IX INVESTIGATOR

Name of investigator: _____ Signature _____ Date: ____/____/____ (Day Month Year)

Title: _____ Office: _____

Comments: _____