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ACUTE FLACCID PARALYSIS 60 DAY FOLLOW-UP INVESTIGATION

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.

INITIAL DIAGNOSIS	
Initial Diagnosis/Notification:	
Date of Notification: *DD/MM/YYYY*	Date Investigation Started: *DD/MM/YYYY*
PATIENT'S DEMOGRAPHICS	
Patient's ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN	Patient's ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Patient's Maiden Name (if applicable):	
Sex Assigned at Birth: ◯ Male ◯ Female	Medical Record Number:
Date of Birth: *DD/MM/YYYY*	Age:
Country of Residence:	Parish (Jamaica):
House Number, Street Name:	
Landmark or directions to address:	Community:
Phone Number:	Email Address:
NEXT OF KIN	
First Name:	Last Name:
Phone number:	Email address:
Address: Lot/ Street/Community/Parish:	
CLINICAL PROFILE	
Date Patient Seen: *DD/MM/YYYY*	Date of Home Visit: *DD/MM/YYYY*

Sign or Symptom	Presence			Date of Onset
Associated Symptoms/Signs				
Cranial Pair Involvement	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Respiratory Symptoms	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*

Duration of Weakness/Paralysis: _____ ◯day ◯hour (s)	
Weakness/Paralysis Progression: ◯Ascending ◯Descending ◯Other	Nadir: *DD/MM/YYYY*

Weakness/Paralysis Findings Per Limb

Limb	Presence of Weakness/Paralysis	Power (/5)	Location of Weakness/Paralysis	Reflex detail	Sensation
Right upper limb	◯ Yes ◯ No ◯ Unknown	____/5	◯ Proximal ◯ Distal ◯ Both	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown
Left upper limb	◯ Yes ◯ No ◯ Unknown	____/5	◯ Proximal ◯ Distal ◯ Both	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown
Right lower limb	◯ Yes ◯ No ◯ Unknown	____/5	◯ Proximal ◯ Distal ◯ Both	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown
Left lower limb	◯ Yes ◯ No ◯ Unknown	____/5	◯ Proximal ◯ Distal ◯ Both	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown	◯ Increased ◯ Normal ◯ Decreased ◯ Absent ◯ Unknown

Summary of Clinical Management:

Classification	
Initial Diagnosis: AFP/Polio	**Final Diagnosis:**

Investigator's Comments:

Investigator's Details		
Date Investigation Completed: *DD/MM/YYYY*		
First Name:	Last Name	
Professional Group:		
Phone number:	Email Address:	
Name of Institution:		
Parish:	Community:	
Office Number/Street Name:		
Health Region:		
Name of Parish MO(H):	Signature of MO(H)	Date signed by MO(H): *DD/MM/YYYY*