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ACUTE FLACCID PARALYSIS 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: Acute Flaccid Paralysis			
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		Date of Birth: *DD/MM/YYYY*	Age:
Name of Facility Where Patient Seen:			Medical Record Number:
Country of Residence:	Community:		Parish (Jamaica):
House Number, Street Name:			
Landmark or directions to address:			
Phone Number:	Email Address:		Occupation:
Name of School/Workplace:			
Address of School/Workplace:			
Phone Number:			Email Address:
NEXT OF KIN			
First Name:	Last Name:		Pet Name(s):
NOK ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN			NOK ID Number:
Address: Lot/ Street/Community/Parish:			
Name of School/ Workplace:			
Address of School/Workplace:			
Phone number:		Email address:	
Relationship to the Patient:			

◯ Wife	◯ Son	◯ Uncle	◯ Cousin
◯ Husband	◯ Daughter	◯ Aunt	◯ Friend
◯ Mother	◯ Sister	◯ Grandmother	◯ Guardian
◯ Father	◯ Brother	◯ Grandfather	◯ Other (specify):

Name of patient: Medical Record Number:

CLINICAL PROFILE

Date Patient Seen: *DD/MM/YYYY* | Date of Home Visit: *DD/MM/YYYY*

Sign or Symptom	Presence			Date of Onset
Prodrome				
Fever (current)	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
History of fever	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Respiratory symptoms	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Diarrhoea	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Associated Symptoms/Signs				
Muscle pain	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Meningeal signs	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Cranial nerve pair involvement	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Weakness/Paralysis				
Weakness/Paralysis	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
Other Symptoms/Signs				
	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*
	◯Yes	◯No	◯Unknown	*DD/MM/YYYY*

Time over which weakness/paralysis developed: _____ ◯day(s) ◯hour(s)

Weakness/Paralysis Progression: ◯Ascending ◯Descending ◯Other | Nadir (date weakness was worst): *DD/MM/YYYY*

Name of patient: Medical Record Number:

Examination Findings Per Limb

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

Name of patient: Medical Record Number:

CASE MANAGEMENT AND INVESTIGATION

Did the patient come in contact with any foreign travelers? ◯ Yes ◯ No ◯ Unknown

Did the patient travel in the Last 7-23 weeks: ◯ Yes ◯ No ◯ Unknown

If travelled: ◯ Domestic Travel ◯ International Travel ◯ Domestic and International Travel

If travelled, fill out the table below (Fill out if contact with foreign traveller as well):

Country Visited	City Visited	Date Arrived in Country	Date Departed Country
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*

Date returned to Jamaica *DD/MM/YYYY*

VACCINATION STATUS

Type of Vaccine	Number of doses	Date of last dose	Source of vaccination Information
OPV		*DD/MM/YYYY*	
IPV		*DD/MM/YYYY*	
Polio Vaccine, Unknown Route of Administration		*DD/MM/YYYY*	

Summary of Clinical Management:

HOSPITAL SUMMARY

Admitted to Hospital? ◯ Yes ◯ No	Date of Admission: *DD/MM/YYYY*	Date of Discharge: *DD/MM/YYYY*
Hospital:	Ward:	Medical Record Number:
Vital Status (Outcome): ◯ Alive ◯ Dead	Date of Death: *DD/MM/YYYY*	Time of Death: __:__ AM/PM

Place of Death: ◯ Home ◯ Dead on Arrival ◯ Ward ◯ ICU ◯ Other, Specify: _____

SAMPLE AND LAB INFORMATION

Was a sample taken? ◯ Yes ◯ No ◯ Unsure

What date was the specimen taken? *DD/MM/YYYY*

Which lab is the sample being sent to?

◯ National Public Health Laboratory ◯ University of the West Indies ◯ Other

Specify Other Laboratory:

Name of patient: Medical Record Number:

Two separate stool samples should be taken at least 24 hours apart and within 14 days of onset of weakness/paralysis.

DIAGNOSTIC INVESTIGATION SCREENING

Virus and Intratypic Isolation

Stool Specimen- Laboratory Details							
Specimen Number	**Date Specimen Collected**	**Date Specimen Sent to Lab**	**Date/time received by laboratory**	**Adequacy for testing**	**Quantitative Test result**	**Test result (Virus Isolation**	**Test result (Virus Isolation)**
1	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive - poliovirus ◯ Positive – Non-Polio Enterovirus (NPEV) ◯ Positive - Poliovirus and NPEV ◯ Negative ◯ Indeterminate ◯ Unknown	◯ PI Sabin ◯ P2 Sabin ◯ P3 Sabin ◯ PI Vaccine-derived ◯ P2 Vaccine-derived ◯ P3 Vaccine-derived ◯ PI Wild
2	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		◯ Positive - poliovirus ◯ Positive – Non-Polio Enterovirus (NPEV) ◯ Positive - Poliovirus and NPEV ◯ Negative ◯ Indeterminate ◯ Unknown	◯ PI Sabin ◯ P2 Sabin ◯ P3 Sabin ◯ PI Vaccine-derived ◯ P2 Vaccine-derived ◯ P3 Vaccine-derived ◯ PI Wild

Laboratory Comments:

Name of patient: Medical Record Number:

CONTACT TRACING	
Contacts should be <5 years of age and not vaccinated within 30 days. List additional contacts on separate page.	
1. First Name:	Last Name(s):
Age: YY/MM	Date of Birth: DD/MM/YYYY
House Number, Street Name:	
Parish:	Community:
Phone Number:	Email Address:
Symptoms: ◯ Yes ◯ No	Specify symptoms:
Number of doses Polio Vaccine:	Date of last dose: DD/MM/YYYY
Specimen Collected: ◯ Yes ◯ No	Date Specimen Collected: DD/MM/YYYY
2. First Name:	Last Name(s):
Age: YY/MM	Date of Birth: DD/MM/YYYY
House Number, Street Name:	
Parish:	Community:
Phone Number:	Email Address:
Symptoms: ◯ Yes ◯ No	Specify symptoms:
Number of doses Polio Vaccine:	Date of last dose: DD/MM/YYYY
Specimen Collected: ◯ Yes ◯ No	Date Specimen Collected: DD/MM/YYYY
3. First Name:	Last Name(s):
Age: YY/MM	Date of Birth: DD/MM/YYYY
House Number, Street Name:	
Parish:	Community:
Phone Number:	Email Address:
Symptoms: ◯ Yes ◯ No	Specify symptoms:
Number of doses Polio Vaccine:	Date of last dose: DD/MM/YYYY
Specimen Collected: ◯ Yes ◯ No	Date Specimen Collected: DD/MM/YYYY
Classification	
Initial Diagnosis: AFP/Polio	**Final Diagnosis:**
Case classification:	

◯ Laboratory Confirmed	◯ Polio Compatible	◯ Vaccine Associated
◯ Vaccine Derived	◯ Inconclusive	◯ Pending
◯ Discarded		

Reason for classification:
Transmission Classification: ◯ Imported ◯ Import-related ◯ Endemic ◯ Local Transmission ◯ Unknown
Source country (If Imported or Import-Related):
DEATH CLASSIFICATION
Polio related death: ◯ Yes ◯ No ◯ Unknown
Immediate Cause:
Intermediate Cause:
Underlying Cause:

Name of patient: Medical Record Number:

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:		
Community:		
Parish:		
Investigator's Office Number/Street Name:		
Investigator's Health Region:		
Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): *DD/MM/YYYY*