**Poliomyelitis/AFM**

**County**

---

**ADMINISTRATIVE**

**Investigator**

LHJ Case ID (optional) ________________________________

LHJ notification date ___/___/___

Classification

- Classification pending
- Confirmed
- Not reportable
- Probable
- Ruled out
- Suspect

Investigation status

- In progress
- Complete
- Complete – not reportable to DOH
- Unable to complete
  - Reason ________________________________

**Investigation start date ___/___/___**

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related

- Yes
- No

LHJ Cluster ID __________ Cluster Name ______________

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**REPORT SOURCE**

Initial report source

- LHJ

Reporter organization ________________________________

Reporter name ________________________________

Reporter phone ________________________________

All reporting sources (list all that apply)

---

**CLINICAL INFORMATION**

Complainant ill

- Yes
- No
- Unk

Symptom Onset ___/___/___

- Derived

Diagnosis date ___/___/___

Illness duration ________

- Days
- Weeks
- Months
- Years

Illness is still ongoing

- Yes
- No
- Unk

---

**COMMUNICATIONS**

Primary HCP name ________________________________

Phone ________________________________

OK to talk to patient

- Yes
- Later ___/___/___
- Never

Date of interview attempt ___/___/___

- Complete
- Partial
- Unable to reach

Patient could not be interviewed

Alternate contact

- Parent/Guardian
- Spouse/Partner
- Friend
- Other ________________________________

Contact name ________________________________

Contact phone ________________________________

---

**Poliomyelitis required variables are in **bold**. Answers are: Yes, No, Unknown to case**
<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>Malaise</td>
<td>Headache</td>
</tr>
<tr>
<td>Invasive ventilator support</td>
<td><strong>Myalgia</strong> (muscle aches or pain)</td>
<td>Nausea</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Altered mental state</td>
<td>Sensory deficit</td>
</tr>
<tr>
<td>Seizure new with disease</td>
<td><strong>Nuchal rigidity</strong> (stiff neck)</td>
<td>Other apparent cause of paralysis (e.g., trauma to affected limb, spinal cord injury) Specify</td>
</tr>
<tr>
<td>Pain or burning in the affected limbs</td>
<td>Sensory level on torso (i.e., reduced sensation below a certain level of the torso)</td>
<td><strong>Paralysis in one or more limbs</strong></td>
</tr>
<tr>
<td>Acute onset</td>
<td>Onset date <em><strong>/</strong></em>/___</td>
<td>Limbs affected</td>
</tr>
<tr>
<td>Symmetry</td>
<td>Symmetric</td>
<td>Asymmetric</td>
</tr>
<tr>
<td>Nature of progression</td>
<td>Ascending</td>
<td>Descending</td>
</tr>
<tr>
<td>Follow-up assessment of status at 60 days or more after onset</td>
<td>If Done, Paralysis present 60 days or more after onset</td>
<td></td>
</tr>
</tbody>
</table>

**Date of neurological exam ___/___/___**

**Predisposing Conditions**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral etiology identified</td>
<td><strong>Viral agent</strong></td>
<td>HIV positive/AIDS</td>
</tr>
<tr>
<td>History of acute respiratory illness (30 days prior to onset)</td>
<td></td>
<td>Received any immunosuppressing agents (30 days prior to onset) Specify</td>
</tr>
<tr>
<td>Immunosuppressive therapy or condition, or disease</td>
<td>Specify</td>
<td>Injections received within 30 days prior to onset with date</td>
</tr>
<tr>
<td>Site of injection</td>
<td></td>
<td>Substance</td>
</tr>
<tr>
<td>Abnormal neurological history</td>
<td>Specify</td>
<td>Any other underlying illness Specify</td>
</tr>
</tbody>
</table>

**Vaccination**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever received polio containing vaccine</td>
<td>Number of polio doses prior to illness</td>
<td><strong>Vaccine series not up to date reason</strong></td>
</tr>
<tr>
<td>Religious exemption</td>
<td>Medical contraindication</td>
<td>Philosophical exemption</td>
</tr>
<tr>
<td>Laboratory confirmation of previous disease</td>
<td>MD diagnosis of previous disease</td>
<td>Underage for vaccine Parental refusal Other Unknown</td>
</tr>
</tbody>
</table>

**Date of vaccine administration ___/___/___**

**Vaccine administered (Type)**

**Vaccine lot number**

**Administering provider**

**Information source**

**Washington Immunization Information System (WIIS)**

**WIIS ID number**

**Medical record**

**Patient vaccination card**

**Verbal only/no documentation**

**Other state IIS**

Y N Unk

**Polio vaccination up to date for age per ACIP**

**Vaccine series not up to date reason**

**Religious exemption**

**Medical contraindication**

**Philosophical exemption**

**Laboratory confirmation of previous disease**

**MD diagnosis of previous disease**

**Underage for vaccine**

**Parental refusal**

**Other**

**Unknown**
Y N Unk
[ ] [ ] Received any vaccines within the 30 days prior to onset of symptoms
Describe
[ ] [ ] Received OPV within the 30 days prior to onset of symptoms
[ ] [ ] Household member or close contact received OPV within the 90 days prior to onset of symptoms
Describe

Physician Reporting/Patient Health Care

Date of follow-up ___/___/___
Outcome [ ] Fully recovered [ ] Partial recovery with residual paralysis [ ] Outcome pending [ ] Fatal [ ] Unk
If partial recovery
Site of paralysis [ ] Spinal [ ] Bulbar [ ] Spino-bulbar [ ] Specific sites
Severity of paralysis at follow-up [ ] Minor (any minor involvement) [ ] Significant (< 2 extremities, major involvement)
[ ] Severe (> 3 extremities and respiratory involvement) [ ] Unk

Y N Unk
[ ] [ ] Specimens sent to CDC for testing
Type [ ] NP swab [ ] OP swab [ ] Rectal swab [ ] Stool [ ] Whole blood [ ] Serum [ ] CSF
[ ] Other

Hospitalization

Y N Unk
[ ] [ ] Hospitalized at least overnight for this illness
Facility name
Hospital admission date ___/___/___ Discharge ___/___/___ HRN
[ ] [ ] Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
[ ] [ ] Mechanical ventilation or intubation required
[ ] [ ] Still hospitalized As of ___/___/___

Y N Unk
[ ] [ ] Died of this illness Death date ___/___/___ Please fill in the death date information on the Person Screen
[ ] [ ] Autopsy performed
[ ] [ ] Death certificate lists disease as a cause of death or a significant contributing condition
Location of death [ ] Outside of hospital (e.g., home or in transit to the hospital [ ] Emergency department (ED)
[ ] Inpatient ward [ ] ICU [ ] Other

RISK AND RESPONSE (Ask about exposures 3-35 days before symptom onset)

Travel

<table>
<thead>
<tr>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel out of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County/City</td>
<td></td>
<td>County/City</td>
</tr>
<tr>
<td>State</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Country</td>
<td></td>
<td>Country</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Destination name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start and end dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em><strong>/</strong></em> to <em><strong>/</strong></em></td>
<td><em><strong>/</strong></em> to <em><strong>/</strong></em></td>
<td><em><strong>/</strong></em> to <em><strong>/</strong></em></td>
</tr>
</tbody>
</table>

Y N Unk
[ ] [ ] Household member or close contact travelled to, or reside in, another country (30 days prior to onset)
Describe

Risk and Exposure Information

Y N Unk
[ ] [ ] Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor)
Country
[ ] [ ] Contact with recent foreign arrival
Country Date(s) of contact ___/___/___
[ ] [ ] Contact with recent OPV vaccinee
[ ] [ ] Congregate living
<table>
<thead>
<tr>
<th>Barracks</th>
<th>Corrections</th>
<th>Long term care</th>
<th>Dormitory</th>
<th>Boarding school</th>
<th>Camp</th>
<th>Shelter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Water Exposure

Y N Unk
[ ] [ ] Source of drinking water known
Describe
Bottled water
[ ] [ ] Public water system
[ ] [ ] Individual well
[ ] [ ] Shared well
[ ] [ ] Other
[ ] [ ] Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring)
[ ] [ ] Recreational water exposure (e.g., lake, river, pool, waterpark)

Exposure and Transmission Summary

Y N Unk
[ ] [ ] Epidemiologically linked to a lab positive case classified as confirmed
Likely geographic region of exposure  □ In Washington – county ________  □ Other state ________  □ Not in US - country ________  □ Unk

International travel related  □ During entire exposure period  □ During part of exposure period  □ No international travel

Suspected exposure type  □ Foodborne  □ Waterborne  □ Person to person  □ Unk  □ Other __________________________
Describe ____________________________________________

Suspected exposure setting  □ Day care/Childcare  □ School (not college)  □ Doctor’s office  □ Hospital ward  □ Hospital ER  □ Hospital outpatient facility  □ Home  □ Work  □ College  □ Military  □ Correctional facility  □ Place of worship  □ Laboratory  □ Long term care facility  □ Homeless/shelter  □ International travel  □ Out of state travel  □ Transit  □ Social event  □ Large public gathering  □ Restaurant  □ Hotel/motel/hostel  □ Other __________________________
Describe ____________________________________________

Exposure summary

Suspected transmission type (check all that apply)  □ Foodborne  □ Waterborne  □ Person to person  □ Unk
□ Other __________________________
Describe ____________________________________________

Suspected transmission setting (check all that apply)  □ Day care/Childcare  □ School (not college)  □ Doctor’s office  □ Hospital ward  □ Hospital ER  □ Hospital outpatient facility  □ Home  □ Work  □ College  □ Military  □ Correctional facility  □ Place of worship  □ Laboratory  □ Long term care facility  □ Homeless/shelter  □ International travel  □ Out of state travel  □ Transit  □ Social event  □ Large public gathering  □ Restaurant  □ Hotel/motel/hostel  □ Other __________________________
Describe ____________________________________________

Public Health Issues (Polio only)
Evaluated immune status of close contacts  □ Yes  □ No, close contacts not evaluated  □ No, case had no close contacts  □ Unk  □ Unknown
Date initiated ___/___/___
Number of close contacts evaluated for immune status ______
Number of susceptible contacts identified ______
□ No, case had no close contacts  □ Unk

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions (Polio only)

Prophylaxis of appropriate contacts recommended  □ Yes  □ No  □ Unk  □ Unknown  □ Other
Date initiated ___/___/___
Number of contacts recommended prophylaxis ______
Number of contacts receiving prophylaxis ______
Number of contacts completing prophylaxis ______

Strict isolation for incubation period  □ Yes  □ No  □ Unknown  □ Other
Letter sent  Date ___/___/___  Batch date ___/___/___

Any other public health action

TRANSMISSION TRACKING (Polio only)

Contagious period: 1 week prior to symptom onset, 6 weeks after symptom onset
Visited, attended, employed, or volunteered at any public settings while contagious  □ Yes  □ No  □ Unk
Settings and details (check all that apply)  □ Day care  □ School  □ Airport  □ Hotel/Motel/Hostel  □ Transit  □ Health care  □ Home  □ Work  □ College  □ Military  □ Correctional facility  □ Place of worship  □ International travel  □ Out of state travel  □ LTCF  □ Homeless/shelter  □ Social event  □ Large public gathering  □ Restaurant  □ Other
<table>
<thead>
<tr>
<th>Setting Type (as checked above)</th>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
<th>Setting 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Date</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
</tr>
<tr>
<td>End Date</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
</tr>
<tr>
<td>Time of Arrival</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of Departure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people potentially exposed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details (hotel room #, HC type, transit info, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact information available for setting (who will manage exposures or disease control for setting)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is a list of contacts known?</td>
<td>Y □ N □ Unk</td>
<td>Y □ N □ Unk</td>
<td>Y □ N □ Unk</td>
<td>Y □ N □ Unk</td>
</tr>
</tbody>
</table>

If list of contacts is known, please fill out Contact Tracing Form Question Package

**NOTES**

**LAB RESULTS**

Lab report information

Lab report reviewed – LHJ □
WDRS user-entered lab report note

Submitter ________________________________
Performing lab for entire report ________________________________
Referring lab ________________________________

Specimen

Specimen identifier/accession number ________________________________
Specimen collection date ___/___ Specimen received date ___/___

WDRS specimen type _____________________________________________
WDRS specimen source site _______________________________________
WDRS specimen reject reason ____________________________________

Test performed and result

WDRS test performed ________________________________
WDRS test result, coded ________________________________
WDRS test result, comparator ________________________________
WDRS result, numeric only (enter only if given, including as necessary Comparator and Unit of measure) _________
WDRS unit of measure _________
Test method ________________________________
WDRS interpretation code ________________________________
Test result – Other, specify ________________________________

WDRS result summary □ Positive □ Negative □ Indeterminate □ Equivocal □ Test not performed □ Pending

Test result status □ Final results; Can only be changed with a corrected result
□ Preliminary results
□ Record coming over is a correction and thus replaces a final result
□ Results cannot be obtained for this observation
□ Specimen in lab; results pending

Result date ___/___/___

Upload document

Ordering Provider
WDRS ordering provider ________________________________

Ordering facility
WDRS ordering facility name ________________________________