



Poliomyelitis/AFM

County _____

Case name (last, first) _____
 Birth date ___/___/___ Sex at birth F M Other Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

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 _____

DEMOGRAPHICS

Age at symptom onset _____ Years Months
 Ethnicity Hispanic or Latino Not Hispanic or Latino Unk
 Race (check all that apply) Unk Amer Ind/AK Native
 Asian Black/African Amer Native HI/other PI
 White Other _____
 Primary language _____
 Interpreter needed Yes No Unk
 Employed Yes No Unk
 Occupation _____ Work site _____
 Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College
 Graduate School Vocational Online Other
 School name _____
 School address _____
 City/State/County _____ Zip _____
 Phone number _____ Teacher's name _____

REPORT SOURCE

Initial report source _____
 LHJ _____
 Reporter organization _____
 Reporter name _____
 Reporter phone _____
 All reporting sources (list all that apply)

COMMUNICATIONS

Primary HCP name _____
 Phone _____
 OK to talk to patient (If Later, provide date)
 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 _____

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

Y N Unk

Meets criteria for suspect Acute Flaccid Myelitis
 Has polio been adequately ruled out
 Final diagnosis Non-polio AFM with etiology unknown Non-polio AFM with etiology identified Polio

Clinical Features

Y N Unk

Fever If yes, Temp measured? Yes No Highest measured temp _____ °F
 If no,
 Fever in 30 days prior to onset
 Fever 48 hours prior to onset
 Bowel or bladder incontinence
 Cognitive defect
 Cranial nerves feature: diplopia, loss of sensation in face, facial droop, hearing loss, dysphagia, dysarthria
 Decreased or absent tendon reflexes in the affected limbs

Y N Unk

- Fatigue
- Malaise
- Headache**
- Invasive ventilator support
- Myalgia (muscle aches or pain)**
- Nausea
- Vomiting
- Altered mental state
- Sensory deficit
- Seizure new with disease
- Nuchal rigidity (stiff neck)**
- Other apparent cause of paralysis (e.g., trauma to affected limb, spinal cord injury)
Specify _____
- Pain or burning in the affected limbs
- Sensory level on torso (i.e., reduced sensation below a certain level of the torso)
- Paralysis in one or more limbs**
- Acute onset Onset date ___/___/___
Limbs affected Right arm Left arm Left Leg Right Leg
Symmetry Symmetric Asymmetric Unk Other _____
Nature of progression Ascending Descending Unk Other _____
Follow-up assessment of status at 60 days or more after onset Done Not done Lost to follow-up
- If Done, Paralysis present 60 days or more after onset

Date of neurological exam ___/___/___

Predisposing Conditions

Y N Unk

- Viral etiology identified Viral agent _____
- HIV positive/AIDS
- History of acute respiratory illness (30 days prior to onset)
- Received any immunosuppressing agents (30 days prior to onset) Specify _____
- Immunosuppressive therapy or condition, or disease Specify _____
- Injections received within 30 days prior to onset with date
Site of injection _____ Substance _____
- Abnormal neurological history Specify _____
- Any other underlying illness Specify _____

Vaccination

Y N Unk

- Ever received polio containing vaccine Number of polio doses prior to illness _____
- Vaccine information available Yes No
- 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
- 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
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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

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	____/____/____ to ____/____/____	____/____/____ to ____/____/____	____/____/____ to ____/____/____

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

Barracks Corrections Long term care Dormitory Boarding school Camp Shelter

Other _____

Water Exposure

Y N Unk

Describe

Source of drinking water known

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 Date initiated ___/___/___
 Number of close contacts evaluated for immune status _____
 Number of susceptible contacts identified _____
 No, close contacts not evaluated
 No, case had no close contacts
 Unk

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

Public Health Interventions/Actions (Polio only)

Y N Unk
 Prophylaxis of appropriate contacts recommended Date initiated ___/___/___
 Number of contacts recommended prophylaxis _____
 Number of contacts receiving prophylaxis _____
 Number of contacts completing prophylaxis _____
 Public announcement recommended
 Strict isolation for incubation period
 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

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

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 _____