



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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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**

	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 _____