

Acute Flaccid Paralysis Case Investigation Form

Ministry of Health, Malaysia

1	CASE I.D. + PLACE	Name:	Gender:	DOB:	Age:	Hospital Regist No.:		
		Mother's N:	District:	State:				
Residential Address:								
2	REFERRAL + REPORTING	Child initially seen at:				Date first seen:		
		Date of report to EPI/MOH:			Person reporting:			
Report from where? (Institution):		Attending physician:						
Remarks:								
3	HISTORY + PHYSICAL EXAMINATION	Onset of paralysis (date) :			No. of days to maximum paralysis:			
		Main history source: 1.Parents 2.Chart 3.Doctor/Nurse						
At onset (paral.): Fever: Y/N Diarrhoea: Y/N Cough: Y/N								
P A S T H I S T O R Y (last 30 days):		ON EXAMINATION (date) :			SITE OF PARALYSIS:			
Injections ?	Yes / No	FLACCID Paralysis?	Yes / No	(grade mot. strength: 0=abs. to 5=full)				
Recent trauma or animal bite?	Yes / No	Meningeal signs (stiff neck):	Yes / No	left arm :	right arm :			
Any existing neurologic disease?	Yes / No	Paralysis symmetric/asymm.?	Symmetric / Asymm	left leg:	right leg:			
Any recent travel? (Specify below)	Yes / No	Deep tendon reflexes:	Norm. / Red. / Abs.	respirator: yes / no	face: yes / no			
Similar case among contacts?	Yes / No	Any sensory loss?	Yes / No	others (specify): _____				
Remarks:								
4	PRELIMINARY DIAGNOSIS:	A F P:	IF YES: 1. Poliomyelitis 2. Guillain-Barre 3. Transverse Myelitis 4. Traum. Neuritis 5. Myasthenia Gravis 6. Viral Myositis					
		Yes	7. Periodic Paralysis 8. Demyelinating Diseases 9. Cord Compression Diseases 10. Others:					
Name of investigator:		Date:		Signature:				
Address of investigator:								
Remarks:								
5	IMMUNISATION HISTORY	Immunisation card available?			Total No. of OPV doses received:			
		Main reason for not fully immunised: 1.not informed 2.illness 3.refusal 4.unknown 5.other:						
Dates: OPV1: Y/N	OPV(2):	OPV(3):	OPV(4):	OPV(4):	OPV(6):	OPV(7):	IPV/OPV(5)	
Recent OPV to contact? Y/N Date ___ ___ ___		Date 1.outbreak response immunis. ___ ___ ___			Number immunised: _____		% of eligible: _____	
Remarks:								
6	LAB. INFO	Date collected:	Date sent:	Date rec. IMR:	Pos. CPE (IMR):	IMR: PV-Type	Date sent to Ref.:	Ref.-Lab. Result:
		Stool 1: Yes / No	___ ___ ___	___ ___ ___	___ ___ ___	Yes / No	1 2 3	Negative
Stool 2: Yes / No	___ ___ ___	___ ___ ___	___ ___ ___	Yes / No	1 2 3	___ ___ ___	___ ___ ___	wild/vacc. T: 1 2 3
Remarks:								
7	FOLLOW-UP	Case examined >= 60 days after onset paralysis? Yes / No				Date of examination:		
		Date: If not seen, why not? _____				Paralysis/Weakness still present? Yes / No		
Site of residual paralysis: Right leg: Y / N Left leg: Y / N Right arm: Y / N Left arm: Y / N Face: Y / N Other:								
Ability to walk: 1. Cannot walk 2. Walks with assistance 3. Limp 4. Walks normally					Exam. physician:			
Remarks:								
8	FINAL DIAGNOSIS - DATE:		(CONFIRMED POLIO or discarded as polio: Expert Review Committee)					
	1. CONFIRMED	> Virus isolation: Yes / No Residual paralysis: Yes / No Death: Yes / No Lost to follow-up: Yes / No						
2. DISCARDED	1. Guillain-Barre 2. Transverse Myelitis 3. Traumatic Neuritis 4. Unknown 5. Other _____							
Remarks:								
NOTE : Please Fax AFP case investigation form to: 1. Disease Control Division, MOH (Fax No. 03 - 888862/0) 2. Virology Department, Institute for Medical Research (IMR), KL (Fax No:03 - 26936323) with adequate stool samples. 3. Nearest District Health Office Second AFP case investigation form should be sent after 60 days with followup result to the above fax.								