Annex 1

Acute Flaccid Paralysis Case Investigation Form

Ministry of Health, Malaysia

1 CASE I.D. + PLACE

Name: | Gender: | DOB: | Age: | Hospit Regist No.:

Mother's N: | Father'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: | Tel. No.:

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 | Other:

P A S T H I S T O R Y (last 30 days):		ON EXAMINATION (date) :		S I T E O F P A R A L Y S I S:	
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? (Specifiy below)	Yes | No	Deep tendon reflexes:	Norm.| Red.| Abs.	respir.: 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:**

1. Poliomyelitis | 2.Guillain-Barre | 3. Transverse Myelitis | 4. Traum. Neuritis | 5. Myasthenia Gravis | 6. Viral Myositis

7. Periodic Paralysis | 8. Demyelinating Diseases | 9. Cord Compression Diseases | 10. Others :

Name of investigator: | Date: | Signature:

Address of investigator:

Remarks:

5 IMMUNISATION HISTORY / ORI

Immunisation card available? Yes / No | 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 ___|___|___ | OPV2: ___|___|___ | OPV3: ___|___|___ | OPV4:___|___|___ | OPV5___|___|___ | OPV6___|___|___ | OPV7___|___|___ | Last OPV___|___

Remarks:

6 LAB. INFO

	Date collected:	Date sent:	Date rec. IMR:	Pos. CPE (IMR):	IMR: PV-Type	Date sent to Ref.:	Ref.-Lab. Result:
S t o o l 1 : Yes / No				Yes / No	1 | 2 | 3	Negative	wild/vacc. | T: 1|2|3
S t o o l 2 : Yes / No	____|____|____	____|____|____	____|____|____	Yes / No	1 | 2 | 3	____|____|____	wild/vacc. | T: 1|2|3

Remarks: Complete Immunizations

7 FOLLOW-UP Date:

Case examined >= 60 days after onset paralysis? Yes / No | Date of examination:

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. Limps 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. Dr. Zalilah Abdullah, Disease Control Division, MOH (Fax No. 03 - 88886270)

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.