Acute Flaccid Paralysis Case Investigation Form

Ministry of Health, Malaysia

1	CASE ID. + PLACE	Name:	Gender:	DOB:	Age:	Hospit Regist No.:
		Mothers 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:				
	Past History (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 neurological 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.	respir.: yes *I* no | face: yes *I* no	
	Similar case among contacts?	Yes | No	Any sensory loss?	Yes | No	others (specify):	
	Remarks:					

4	PRELIMINARY DIAGNOSIS:	AFP:	If YES: 1. Poliomyelitis | 2.Guillain-Barre | 3. Transverse Myelitis | 4. Traum. Neuritis | 5. Other:
			IF NO: 1. Injury | 2. Spastic paralysis | 3. Joint or bone infection | 4. Other:
	Name of investigator:		Date: Signature:
	Address of investigator:		
	Remarks:		

5	IMMUNISATION	Immunization card available? Yes *I* No				Total No. of OPV doses received:		
	HISTORY /ORI	Main reason for not fully immunized: 1. not informed 2. illness 3. refusal 4. unknown 5. other: ____						
	Date: OPV	Date: OPV2	Date: OPV3	Date: OPV4	Date: OPV5	Date: OPV6	Date: OPV7	Date: Last OPV
	Recent OPV to contact? Y/N | Date__|__|__		Date 1.outbreak response immunize. __|__|__		Number immunized:____		% 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 I: Yes/No				Yes *I* No	1 | 2 | 3		wild/vacc.| T: 1| 2| 3
	Stool 2: Yes/No				Yes *I* No	1 | 2 | 3		wild/vacc.| T: 1| 2| 3
	Remarks:							

7	FOLLOW-UP	Case examined > = 60 days after onset paralysis? Yes *I* No	Date of examination:
		If not seen, why not?	Paralysis/Weakness still present? Yes *I* 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 to:

1. Disease Control Division, MOH (Fax No. 03 - 88891013 or CPRC 03-8881 0400 / 0500
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 follow-up result to the above fax.

Acute Flaccid Paralysis Case Field Investigation Form

Ministry of Health, Malaysia

1	CONTACT HISTORY	Any sibling relatives with the same symptom: Yes / No		If Yes, Please complete the particulars as below:		Hospital Regist No.:	
		Any classmate with the same symptom:					
		Any history of contact with immigrants from polio endemic countries during last 2 weeks (Afghanistan, Pakistan, India, Nigeria). If yes, state the country and date:					
		Any siblings/ neighbors with history of recent Polio immunization (3 weeks before onset of the symptom). If Yes, Date and Place of immunization: Date: Place:					
	Name of the contact	Age	Address	RN (if admit)	Diagnosis	Recent OPY immunization, Date	Recent OPY immunization, Place
2	TRAVEL HISTORY	Any history of traveling for the last 2 weeks. If Yes, state the country and date of traveling					
3	ENVIRONMENT	Inspection Outside the house		Type of refuse disposal		Type of drainage	
		Inspection inside the side		Control of LILATI			
		Type of Toilet		Explain the food and personal hygiene practice			
		Type of Water supply		Any swimming pool around the house / history of swimming in any swimming pool recently (during last 2 week)			
4	ACTION TAKEN	Disinfection. If Yes, state the chemical use and place of disinfection done					
		* If there are cases among contact, please refer the cases to clinician (Paediatrician / Physician)					
		Health Education (state the number of people being given the health education)					
	Remarks:						

NOTE: Please Fax AFP case investigation form to:

1. Disease Control Division, MOH (Fax No. 03 - 8889 1013 or CPRC: 03 - 8881 0400 / 0500
2. Virology Department, Institute for Medical Research (IMR), KL (Fax No:03 - 26936323) with adequate stool samples.
3. Nearest District Health Office

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