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:		District:	State:		
Residenrial 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

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 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.	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: Yes**

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

7. Periodic Paralysis I 8. Demyelinating Diseases I 9. Cord Compression Diseases I _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	wild/vacc. | T: 1|2|3
Stool 2 : **Yes** / No	____|____|____	____|____|____	____|____|____	Yes / No	1 | 2 | 3	____|____|____	wild/vacc. | T: 1|2|3

Remarks:

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 paralys: 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. 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.