MINISTRY OF HEALTH & WELLNESS

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NATIONAL EPIDEMIOLOGY BRANCH

ACUTE FLACCID PARALYSIS INVESTIGATION

Complete this form for any person aged <15 years with acute flaccid paralysis, and for a person of any age in whom polio is suspected.

INITIAL DIAGNOSIS

Initial Diagnosis/Notification: Acute Flaccid Paralysis

Date of Notification (DD/MM/YYYY):	Date Investigation Started (DD/MM/YYYY):

PATIENT'S DEMOGRAPHICS

Patient's ID Type: ☐ Driver's License ☐ TRN ☐ Passport ☐ NIN	Patient's ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Patient's Maiden Name (if applicable):	
Sex Assigned at Birth: ☐ Male ☐ Female	Medical Record Number:
Date of Birth (DD/MM/YYYY):	Age:
Country of Residence:	Parish (Jamaica):
House Number, Street Name:	
Landmark or directions to address:	Community:
Phone Number:	Email Address:

Occupation:	
Name of Workplace/School:	
Address of School/Workplace:	
Phone Number:	Email Address:

NEXT OF KIN

First Name:	Last Name:
Phone number:	Email Address:
Address: Lot/ Street/Community/Parish:	
Relationship to the Patient:	

☐ Wife	☐ Son	☐ Uncle	☐ Cousin
☐ Husband	☐ Daughter	☐ Aunt	☐ Friend
☐ Mother	☐ Sister	☐ Grandmother	☐ Guardian
☐ Father	☐ Brother	☐ Grandfather	☐ Other (specify):

MOTHER'S INFORMATION (If not next of kin)

ID Type: ☐ Driver's License ☐ TRN ☐ Passport ☐ NIN	ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Maiden Name:	
House Number, Street Name:	
Community:	Parish (Jamaica):
Phone Number:	Email Address:

CLINICAL PROFILE

Date Patient Seen: DD/MM/YYYY | Date of Home Visit: DD/MM/YYYY

Sign or Symptom	Presence	Date of Onset DD/MM/YYYY
Prodrome		
Fever (current)	☐ Yes ☐ No ☐ Unknown	
History of fever	☐ Yes ☐ No ☐ Unknown	
Respiratory symptoms	☐ Yes ☐ No ☐ Unknown	
Diarrhoea	☐ Yes ☐ No ☐ Unknown	
Associated Symptoms/Signs		
Muscle pain	☐ Yes ☐ No ☐ Unknown	
Meningeal signs	☐ Yes ☐ No ☐ Unknown	
Cranial pair involvement	☐ Yes ☐ No ☐ Unknown	
Weakness/Paralysis		
Weakness/Paralysis	☐ Yes ☐ No ☐ Unknown	

Time over which weakness/paralysis developed: _____ day(s) hour(s)

Weakness/Paralysis Progression: ☐ Ascending ☐ Descending ☐ Other

Nadir: DD/MM/YYYY

Paralysis Findings Per Limb

Limb	Presence of Weakness/Paralysis	Power (/5)	Location of Weakness/Paralysis	Reflex detail	Sensation
Right upper limb	☐ Yes ☐ No ☐ Unknown	____/5	☐ Proximal ☐ Distal ☐ Both	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown
Left upper limb	☐ Yes ☐ No ☐ Unknown	____/5	☐ Proximal ☐ Distal ☐ Both	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown
Right lower limb	☐ Yes ☐ No ☐ Unknown	____/5	☐ Proximal ☐ Distal ☐ Both	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown
Left lower limb	☐ Yes ☐ No ☐ Unknown	____/5	☐ Proximal ☐ Distal ☐ Both	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown	☐ Increased ☐ Normal ☐ Decreased ☐ Absent ☐ Unknown

VACCINATION STATUS

Type of Vaccine	Number of doses	Date of last dose DD/MM/YYYY	Source of vaccination Information
OPV			
IPV			
Polio Vaccine, Unknown			
Route of Administration			

Summary of Clinical Management:

HOSPITAL SUMMARY

Admitted to Hospital? ☐ Yes ☐ No	Date of Admission: DD/MM/YYYY	Date of Discharge: DD/MM/YYYY
Hospital:	Ward:	Medical Record Number:
Vital Status (Outcome): ☐ Alive ☐ Dead	Date of Death: DD/MM/YYYY	Time of Death: __:__ AM/PM

Place of Death: ☐ Home ☐ Dead on Arrival ☐ Ward ☐ ICU ☐ Other, Specify: _____

SAMPLE AND LAB INFORMATION

Was a sample taken? ☐ Yes ☐ No ☐ Unsure

What date was the specimen taken? DD/MM/YYYY

Which lab is the sample being sent to?

☐ National Public Health Laboratory ☐ University of the West Indies ☐ Other

Specify Other Laboratory:

AFP INVESTIGATION

MEDICAL RECORD NUMBER:

Two separate stool samples should be taken at least 24 hours apart and within 14 days of onset of weakness/paralysis.

DIAGNOSTIC INVESTIGATION SCREENING

Virus and Intratypic Isolation

Stool Specimen- Laboratory Details

Specimen Number	Date Specimen Collected DD/MM/YYYY	Date Specimen Sent to Lab DD/MM/YYYY	Date/time received by laboratory DD/MM/YYYY	Adequacy for testing	Quantitative Test result	Test result (Virus Isolation)	Test result (Virus Isolation)
1				☐ Satisfactory - analysed ☐ Unsatisfactory- analysed ☐ Unsatisfactory – not analysed		☐ **Positive - poliovirus** ☐ **Positive – Non-Polio Enterovirus (NPEV)** ☐ **Positive - Poliovirus and NPEV** ☐ **Negative** ☐ **Indeterminate** ☐ **Unknown**	☐ **PI Sabin** ☐ **P2 Sabin** ☐ **P3 Sabin** ☐ **PI Vaccine-derived** ☐ **P2 Vaccine-derived** ☐ **P3 Vaccine-derived** ☐ **PI Wild**
2				☐ Satisfactory - analysed ☐ Unsatisfactory- analysed ☐ Unsatisfactory – not analysed		☐ **Positive - poliovirus** ☐ **Positive – Non-Polio Enterovirus (NPEV)** ☐ **Positive - Poliovirus and NPEV** ☐ **Negative** ☐ **Indeterminate** ☐ **Unknown**	☐ **PI Sabin** ☐ **P2 Sabin** ☐ **P3 Sabin** ☐ **PI Vaccine-derived** ☐ **P2 Vaccine-derived** ☐ **P3 Vaccine-derived** ☐ **PI Wild**

Laboratory Comments:

AFP INVESTIGATION

MEDICAL RECORD NUMBER:

CONTACT TRACING

Contacts should be <5 years of age and not vaccinated within 30 days. List additional contacts on separate page.

1. First Name:	Last Name(s):
Age: YY/MM	Date of Birth: DD/MM/YYYY
House Number, Street Name:	
Parish:	Community:
Phone Number:	Email Address:
Symptoms: ☐ Yes ☐ No	Specify symptoms:
Number of doses Polio Vaccine:	Date of last dose: DD/MM/YYYY
Specimen Collected: ☐ Yes ☐ No	Date Specimen Collected: DD/MM/YYYY
2. First Name:	Last Name(s):
Age: YY/MM	Date of Birth: DD/MM/YYYY
House Number, Street Name:	
Parish:	Community:
Phone Number:	Email Address:
Symptoms: ☐ Yes ☐ No	Specify symptoms:
Number of doses Polio Vaccine:	Date of last dose: DD/MM/YYYY
Specimen Collected: ☐ Yes ☐ No	Date Specimen Collected: DD/MM/YYYY
3. First Name:	Last Name(s):
Age: YY/MM	Date of Birth: DD/MM/YYYY
House Number, Street Name:	
Parish:	Community:
Phone Number:	Email Address:
Symptoms: ☐ Yes ☐ No	Specify symptoms:
Number of doses Polio Vaccine:	Date of last dose: DD/MM/YYYY
Specimen Collected: ☐ Yes ☐ No	Date Specimen Collected: DD/MM/YYYY

Classification

Initial Diagnosis: AFP/Polio		**Final Diagnosis:**	
Case classification:			
☐ Laboratory Confirmed	☐ Polio Compatible	☐ Vaccine Associated	☐ Vaccine Derived
☐ Inconclusive	☐ Pending	☐ Discarded	

Reason for classification:

Transmission Classification: ☐ Imported ☐ Import-related ☐ Endemic ☐ Local Transmission ☐ Unknown

Source country (If Imported or Import-Related):

DEATH CLASSIFICATION

Polio related death: ☐ Yes ☐ No ☐ Unknown

Immediate Cause:

Intermediate Cause:
Underlying Cause:
Investigator's Comments:

Investigator's Details
Date Investigation Completed: DD/MM/YYYY
First Name:
Last Name
Professional Group:
Phone number:
Email Address:
Name of Institution:
Community:
Parish:
Investigator's Office Number/Street Name:
Investigator's Health Region:

Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): DD/MM/YYYY