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ACUTE FLACCID PARALYSIS 60 DAY FOLLOW-UP 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:			
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):	
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	◯ Father	◯ Uncle	◯ Grandfather
◯ Husband	◯ Brother	◯ Aunt	◯ Cousin
◯ Mother	◯ Sister	◯ Grandmother	◯ Friend
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:		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
Associated Symptoms/Signs		
Cranial Pair Involvement	◯Yes ◯No ◯Unknown	*DD/MM/YYYY*
Respiratory Symptoms	◯Yes ◯No ◯Unknown	*DD/MM/YYYY*

Duration of Weakness/Paralysis: _____ ◯day ◯hour (s)

Weakness/Paralysis Progression: ◯Ascending ◯Descending ◯Other | Nadir: *DD/MM/YYYY*

Weakness/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

Summary of Clinical Management:

Classification

Initial Diagnosis: AFP/Polio | **Final Diagnosis:**

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:

Parish:	Community:	
Office Number/Street Name:		
Health Region:		
Name of Parish MO(H):	Signature of MO(H)	Date signed by MO(H): *DD/MM/YYYY*