NEW EPID/37/1/R2004

EPIDEMIOLOGY UNIT MINISTRY OF HEALTH

Serial No. ☐☐☐☐ AFP ID Code SRL/☐☐/☐☐/☐☐/☐☐☐

POLIO ERADICTION INITIATIVE

ACUTE FLACCID PARALYSIS
[AFP]/SUSPECTED POLIOMYELITIS
FORM No. 1

To be filled in by the Medical Officer treating the case, on suspicion of the diagnosis sent to the EPIDEMIOLOGICAL UNIT, 231, DE SARAM PLACE, COLOMBO 01000 (Fax: 2696583, e-mail: epidunit@sltnet.lk, chepid@sltnet.lk immediately. If appropriate, mark '✓' in the box. DO NOT WRITE IN THE SHADED AREAS.

A. GENERAL

1. Date of Notification to MOH: 1. ☐☐.☐☐.☐☐☐☐ (DD MM YYYY)

2. Officer notifying the case:_____ 2 ☐

3. Have you notified this case to the Epidemiologist by telephone (2695112) or fax (2696583) or by telegram? ☐ 1.Yes ☐ 2. No 3 ☐

4. If yes, when? 4.☐☐.☐☐.☐☐☐☐ (DD MM YYYY)

5. Name of Institution: _____ 5. ☐☐☐☐☐

6. Ward No.: 6 ☐☐☐

7. Date of admission: 7. ☐☐.☐☐.☐☐☐☐ (DD MM YYYY)

8. Bed Head Ticket No.: 8. ☐☐☐☐☐☐

B. PARTICULARS OF THE PATIENT:

9. Name of the patient: _____

10. Name of the Parent or Guardian: _____

11. Residential Address (FROM THE PARENT/GUARDIAN AND NOT FROM THE B.H.T.): _____

12. MOH area of residence: _____ 12. ☐☐☐☐

13. Date of Birth: ☐☐.☐☐.☐☐☐☐ (DD MM YYYY)

If Date of birth is not known go to 14. Else go to 15.

14. Age: ☐☐.☐☐ (YY MM)

15. Sex: ☐1. Male ☐ 2. Female 15. ☐

C. SYMPTOMS AND SIGNS

16. Did the patient have fever ☐ 1.Yes ☐ 2. No 16. ☐

17. Date of onset of fever ☐☐.☐☐.☐☐☐☐ (DD MM YYYY)

18. Did the patient have paralysis? Yes ☐ No ☐

19. Date of onset of paralysis . ☐☐.☐☐.☐☐☐☐ (DD MM YYYY)

20. Any injections 30 days before paralysis onset Yes ☐ No ☐
21. Type of paralysis? Spinal ☐ Bulbar ☐ Spino bulbar ☐
A. Asymmetric paralysis? Yes ☐ No ☐
B. Maximum Paralysis reached within 4 days Yes ☐ No ☐
After 4 days Yes ☐ No ☐

20. ☐
21. ☐

22. Site of paralysis (Fill in all the appropriate spaces below)

22. ☐

Site of involvement	Severity of paralysis	Sensation		Site of involvement	Severity of paralysis	Sensation	
	Grade (Please fill in according to key)				Grade (Please fill in according to key)		
Left hand				Right hand			
Left forearm				Right forearm			
Left shoulder				Right shoulder			
Left hip				Right hip			
Left leg				Right leg			
Left foot				Right foot			
Left side of face				Right side of face			
Respiratory Paralysed? (Please tick)		Yes	No	Neck	Right		
					Left		
Other specify ……				Other specify ……			

Key for grading of severity of paralysis (Medical Research Council – MRC – scale):

Grade 0 = Complete paralysis
Grade 1 = A flicker of contraction only
Grade 2 = Power detectable only when gravity is excluded by appropriate postural adjustment.
Grade 3 = The limb can be held against the force of gravity, but not against the examiner's resistance
Grade 4 = There is some degree of weakness usually described as poor, fair or moderate in strength.

D. LABORATORY INVESTIGATIONS

23. 1st specimen of stools 23a. ☐

(i) date of collection 23b. ☐☐.☐☐.☐☐☐☐
DD MM YYYY

(ii) date of despatch 23c. ☐☐.☐☐.☐☐☐☐
DD MM YYYY

24. 2nd specimen of stools 24a. ☐

(i) date of collection 24b. ☐☐.☐☐.☐☐☐☐
DD MM YYYY

(ii) date of despatch 24c. ☐☐.☐☐.☐☐☐☐
DD MM YYYY

E. IMMUNIZATION

25. The number of doses of routine OPV given, with dates

25. ☐

Dose	1			2			3			4			5		
Date	D	M	Y	D	M	Y	D	M	Y	D	M	Y	D	M	Y

26. Last date of OPV immunization (including NIDs): ☐☐.☐☐.☐☐☐☐
27. Has any member of the household (including the patient) had OPV during the last 28 days?
☐ Yes ☐ No ☐ Unknown

27. ☐
28. ☐

28. Probable Diagnosis: _____

29. Name of Medical Officer: _____
30. Designation: _____ 31. Signature:_____
32. Date: _____ ☐☐.☐☐.☐☐☐☐

33. Date of investigation by an Epidemiologist 33. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐