

POLIOMYELITIS, PARALYTIC INVESTIGATION FORM

Comments: _____

Basic Demographic Data

Last Name: _____ First Name: _____
 Middle Name: _____ Suffix: _____
 DOB: ___ / ___ / _____ Current Sex: Female Male Unknown
 Is the patient deceased? No Unknown Yes Deceased Date: ___ / ___ / _____
 Marital Status: (Circle) S / M / D / W / Annulled / Cohabiting / Legally Separated / Polygamous / Unknown
 SSN: ___ ___ / ___ / _____
 Street Address 1: _____
 Street Address 2: _____
 City: _____ State: _____
 Zip Code: _____ - _____ County: _____ Country: _____
 Home Phone: (____) -- _____ - _____ Ext. _____
 Work Phone: (____) -- _____ - _____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race : Unknown American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Reporting Source

Date of Report: ___ / ___ / _____
 Reporting Source: _____
 Earliest Date Reported to: County : ___ / ___ / _____ State: ___ / ___ / _____
 Reporter's Name: _____

Clinical

Physician's Name: _____
 Physician's Phone Number: (____) -- _____ - _____ Ext. _____
 Physician's Address: _____
 City: _____ State: _____
 Zip Code: _____ - _____ County: _____ Country _____

Hospital

Was patient hospitalized for this illness? No Unknown Yes
 If yes: Hospital Name: _____
 Admission Date ___ / ___ / _____ Discharge Date ___ / ___ / _____
 Total Duration of stay within hospital _____ days

Condition

Diagnosis Date: ___ / ___ / _____ Illness Onset Date: ___ / ___ / _____
 Illness End Date: ___ / ___ / _____
 Illness Duration: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
 Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
 Did the patient die from this illness? No Unknown Yes

Epidemiologic

Is this patient associated with a day care facility?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes	Is this patient a food handler?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Is this case part of an outbreak?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes	If yes, outbreak name: _____	

Where was the disease acquired?

<input type="checkbox"/> Indigenous within jurisdiction	<input type="checkbox"/> Out of Country	<input type="checkbox"/> Out of jurisdiction, from another jurisdiction
<input type="checkbox"/> Out of state	<input type="checkbox"/> Unknown	

If the answer is out of Country, Jurisdiction, or State

Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

<input type="checkbox"/> Airborne	<input type="checkbox"/> Bloodborne	<input type="checkbox"/> Dermal	<input type="checkbox"/> Foodborne	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Mechanical
<input type="checkbox"/> Nosocomial	<input type="checkbox"/> Sexually Transmitted	<input type="checkbox"/> Vectorborne	<input type="checkbox"/> Waterborne	<input type="checkbox"/> Zoonotic	<input type="checkbox"/> Other

Detection Method

<input type="checkbox"/> Patient Self-referral	<input type="checkbox"/> Prenatal Testing	<input type="checkbox"/> Prison Entry Screening	<input type="checkbox"/> Provider Reported	<input type="checkbox"/> Routine Physical	<input type="checkbox"/> Other
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Confirmation Method

<input type="checkbox"/> Active Surveillance	<input type="checkbox"/> Case Outbreak Investigation	<input type="checkbox"/> Clinical Diagnosis	<input type="checkbox"/> Epidemiologically Linked
<input type="checkbox"/> Laboratory Confirmed	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Local/State Specified	<input type="checkbox"/> Medical Record Review
<input type="checkbox"/> No information given	<input type="checkbox"/> Occupational Disease Surveillance	<input type="checkbox"/> Provider Certified	<input type="checkbox"/> Other

Confirmation Date: : ___ / ___ / _____

CASE STATUS: (Required for Notification) Confirmed Not a Case Probable Suspect Unknown

MMWR Week _____ MMWR Year _____

Custom Fields

Date Due ___ / ___ / _____

Investigation Ready for Supervisor Review:

 Reviewed (Complete) Reviewed (Incomplete) Reviewed (Not a case) Yes

Date Investigation ready for supervisor review: ___ / ___ / _____

Birth Information:

Birth Country (required field): _____ If Foreign Born, Number of Years in US _____

If yes, to associated with a school or daycare? Answer questions below:

Name of school or daycare:

City of school or daycare:

County of school or daycare:

What grades attend the school (ie: K-12, K-6, 7-12, 7-8, 5-8, 9-12)

What grade is the case in at the school?

Are there other cases in the classroom or other cases in the school building, or both? Explain:

Clinical criteria for case classificationAcute onset of a flaccid paralysis: No Unknown YesThe patient has a neurologic deficit 60 days after onset of initial symptoms : No Unknown YesDid the patient die: No Unknown YesPatient has unknown follow-up status: No Unknown Yes