**PATIENT DETAILS**

**Surname** **Forename** **CIDR ID**

**Sex**  Choose an item. **DOB** dd/mm/yyyy. **Ethnicity** Choose an item. **If Other**

**County** Choose an item.

**Country of infection** 

**REPORTING CLINICIAN’S DETAILS**

**Hospital** **Referring Hospital**

**Consultant** **Referring Consultant**

**Email**

**Date of Hospital Admission** dd/mm/yyyy. **Date of Discharge** dd/mm/yyyy.

**GP DETAILS**

**GP NAMEGP Address****TEL**

**CLINICAL FEATURES AND INVESTIGATIONS**

|  |  |
| --- | --- |
| **Fever at onset of paralysis?** Choose an item.  **Rapid paralysis progression** (within 14 days)? Choose an item.  **Asymmetric paralysis?** Choose an item.  **Patient hospitalised?** Choose an item.  **Patient immunosuppressed?** Choose an item.  **Sensory level detected on examination?** Choose an item.  **Cranial nerve involvement?** Choose an item.  **Bladder or bowel involvement?** (incl. urinary retention/incontinence) Choose an item.  **Respiratory illness/symptoms?** Choose an item.  **Rash?** Choose an item.  **Date of onset of paralysis** dd/mm/yyyy. | **Site of paralysis?**  Facial paralysis only  Limb  Limbs & resp. muscles (bulbar)  Bulbar only  Limb plus facial paralysis  Unknown  Please specify additional details, if any |

**BIOMED INVESTIGATIONS & RESULTS**

Please indicate of any of the following have been performed

EMG? Choose an item. Spinal MRI? Choose an item. dd/mm/yyyy. dd/mm/yyyy.

Brain MRI? Choose an item. CXR? Choose an item. dd/mm/yyyy. dd/mm/yyyy.

Please specify additional details, if any

**VIROLOGY TESTING by NVRL (National Virus Reference Laboratory) Please send specimens to NVRL**

**Stool Specimen 1** dd/mm/yyyy. **Stool Specimen 2**  dd/mm/yyyy.

Lab Result Stool Specimen 1 Lab Result Stool Specimen 2

**** ****

Second stool specimen should be taken >=24 hours after first specimen and both specimens taken within 14 days of onset of paralysis

**Respiratory Specimens**

|  |  |
| --- | --- |
| **Throat Swab?** Choose an item.  Date collected dd/mm/yyyy.  **Nasopharyngeal swab/aspirate?**Choose an item. Date collected dd/mm/yyyy.  **Lumbar puncture (LP)/CSF?** Choose an item.  Date collected dd/mm/yyyy.  Results: | **Serology?** Choose an item.  Date collected dd/mm/yyyy.  Serology Results: |

**CSF Results:**

No. of PMN  Glucose mmol/L 

No. of Lymphocytes  Protein g/L 

No. of RBCs 

**PATIENT VACCINATION HISTORY**

Has patient ever been immunized against polio ? Choose an item.

If YES, date of most recent polio vaccination? dd/mm/yyyy.

Vaccine Type Oral: IPV: Vaccination Date

Ist Dose   dd/mm/yyyy.

2nd Dose   dd/mm/yyyy.

3rd Dose   dd/mm/yyyy.

4th Dose   dd/mm/yyyy.

Comment/Other Details e.g. vaccine brand and batch number



**RISK FACTORS**

Has patient been in contact with someone who received oral polio vaccine within 6 weeks prior to onset of symptoms? Choose an item.

Has patient travelled overseas in the last 3 months? Choose an item. Country 

Date of Departure dd/mm/yyyy. Date of Return dd/mm/yyyy.

Respiratory illness in 4 weeks before onset? Choose an item. dd/mm/yyyy.

Gastrointestinal illness in 4 weeks before onset?Choose an item. dd/mm/yyyy.

Rash in 4 weeks before onset? Choose an item. dd/mm/yyyy.

Any underlying illness in 4 weeks before onset? Choose an item.

If YES, describe 

**DIAGNOSIS (Please indicate if any of the following have been diagnosed in light of current available evidence)**

|  |  |
| --- | --- |
| **Peripheral neuropathy**  Guillain-Barre syndrome (acute post- infectious polyneuropathy)  **Anterior horn cell disease**  Acute poliomyelitis  Vaccine-associated poliomyelitis  Other neurotropic viruses  Hopkins’ syndrome | **Acute myelopathy**  Transverse myelitis  Acute disseminated encephalomyelitis (ADEM)  Spinal cord ischaemia  Spinal cord injury including trauma  Peri-operative complication  Other |

|  |  |
| --- | --- |
| **Systemic disease**  Acute porphyria  Critical illness neuropathy/myopathy  Conversion disorder  **Disorders of neuromuscular transmission**  Botulism  Insecticide *e.g. organophosphate poisoning*  Tick bite paralysis | **Muscle disorders**  Periodic paralyses  Mitochondrial diseases (infantile type)  Viral myositis  Other  Other clinical information |

**OUTCOME AT TIME OF REPORTING**

Date Follow-up? dd/mm/yyyy. Did the patient survive the illness? Yes  No

If NO, date of death dd/mm/yyyy.

Does the patient have any residual paralysis? YesNo If NO, duration of paralysis days?

If YES, describe 

**PATIENT NAME:**

|  |
| --- |
| COMMENTS Including other diagnosis not mentioned |
|  |
| **CASE DEFINITION**: Acute anterior poliomyelitis (Polio virus)  Clinical criteria  Any person <15 years of age with acute flaccid paralysis (AFP) OR Any person in whom polio is suspected by a physician  Laboratory criteria  At least one of the following three:  · Isolation of a polio virus and intratypic differentiation– Wild polio virus (WPV)  ·Vaccine derived poliovirus (VDPV) (for the VDPV at least 85% similarity with vaccine virus in the nucleotide sequences in the VP1 section)  · Sabin-like poliovirus: intratypic differentiation performed by a WHO-accredited polio laboratory (for the VDPV a >1% up to 15% VP1 sequence difference compared with vaccine virus of the same serotype)  Epidemiological criteria  At least one of the following two epidemiological links:  · Human to human transmission  · A history of travel to a polio-endemic area or an area with suspected or confirmed circulation of poliovirus  Case classification  A. **Possible case:** Any person meeting the clinical criteria (in the absence of any alternative diagnosis)  B. **Probable case:** Any person meeting the clinical criteria and with an epidemiological link  C. **Confirmed case:**Any person meeting the clinical and the laboratory criteria  Current as of: 28 May 2018 |

**Note regarding ethic identifier**: This should be self-reported and is that to which the individual case identifies him or herself. It should not be ‘given’ by investigator.

PLEASE USE THE BACK OF THIS QUESTIONNAIRE IF YOU HAVE ANY FURTHER INFORMATION THAT MAY HELP US

**Thank you for contributing to AFP surveillance and the WHO polio eradication program**

Form completed by:Date of Completion dd/mm/yyyy.

Contact telephone number: **** Email: ****

**Thank you for completing this form. Please return the completed form to the Medical Officer of Health at your local Department of Public Health. For who to notify, see** <https://www.hpsc.ie/notifiablediseases/whotonotify/>