



ACUTE FLACCID PARALYSIS
60 Day Follow-Up
Questionnaire
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REPORTING CLINICIAN'S DETAILS

Date of Notification to National Virus Reference laboratory (NVRL):

Date of Notification to Health Protection Surveillance Centre (HPSC):

Dr Name Dr Address

Dr Telephone Fax Email

Hospital Name Hospital Chart Number

PATIENT DETAILS

CIDR Event ID Surname Forename

Address:

HSE Area:

Sex: F M NK Date of Birth: Age (years): Age (months):

60 DAY OUTCOME

Did the patient survive the illness? Yes No NK

If NO, please give the number of days between onset of analysis and death days

Does the patient have any residual paralysis at 60 days after onset of paralysis? Yes No NK

If NO, what was the total duration of paralysis? days

Is there residual sphincter dysfunction? Yes No NK

Has your diagnosis changed since you originally notified this case? Yes No

Date of Follow-up

If yes, please indicate the final diagnosis (below) and the clinical features and investigation findings that support the revised diagnosis:

FINAL DIAGNOSIS

In light of currently available evidence, what is the patient's diagnosis? (Please indicate on list below)

Peripheral neuropathy

Guillain-Barre syndrome (acute post-infectious polyneuropathy)

Acute myelopathy

Transverse myelitis

Acute disseminated encephalomyelitis (ADEM)

Spinal cord ischaemia

Spinal cord injury including trauma

Peri-operative complication

Other (specify)

Anterior horn cell disease

Acute poliomyelitis

Vaccine-associated poliomyelitis

Other neurotropic viruses

Hopkins' syndrome

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