

**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):

**PATIENT VACCINATION HISTORY**

Has the patient ever been immunized against polio? Yes  No  Unknown

If YES, date of last polio vaccination?  Unknown

Type of polio vaccine Oral  IPV

Has the patient been in contact with someone who received oral polio vaccine within 6 weeks prior to onset of symptoms? Yes  No  Unknown

Has the child travelled overseas in the last 3 months? Yes  No  Unknown

If YES, please specify where

**CLINICAL FEATURES AND INVESTIGATIONS**

Date of onset of paralysis (dd/mm/yy)

Presence of fever at onset of paralysis Yes  No  NK

Rural progression of paralysis (within 14 days) Yes  No  NK

Presence of asymmetric paralysis Yes  No  NK

Was the patient hospitalised? Yes  No  NK

Was the patient immunosuppressed? Yes  No  NK  If YES, specify \_\_\_\_\_

Was a sensory level detected on examination? Yes  No  NK  If YES, specify \_\_\_\_\_

Was there cranial nerve involvement? Yes  No  NK  If YES, specify \_\_\_\_\_

Was there bladder and/or bowel involvement? (e.g. urinary retention/incontinence) Yes  No  NK  If YES, specify \_\_\_\_\_

Was a lumbar puncture done? Yes  No  NK

If YES  
CSF: protein  g/L glucose  mmol/L Site of paralysis? \_\_\_\_\_

Number of  PMN  Lymphocyte  RBC;  Other

Were nerve conduction studies done? Yes  No  NK  If YES, specify results \_\_\_\_\_

Was a spinal MRI done? Yes  No  NK

If YES, specify findings \_\_\_\_\_

AFP Form V1.5 31/03/2011

