ACUTE FLACCID PARALYSIS
60 Day Follow-Up Questionnaire

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

hpsc

UCD DUBLIN

PATIENT DETAILS

HSE ID
Surname:
Forename
Address:
County:
Hospital Chart Number
Date of Hospital Admission
Date of Discharge (if known)
Date of Birth
Sex M F Unk

Ethnic groups (see note at end of page)

Irish | Irish Traveller | African | Chinese | Any other Black background | Any other Asian background | Any other White background | Other | Other, please specify

County of Birth:

REPORTING CLINICIAN'S DETAILS

Consultant Name:
Hospital:
Email:

GP DETAILS

GP Name:
GP Tel:
GP Address
Email

60 DAY OUTCOME

Date of Follow-up

	Yes	No	Unk
Did the patient survive the illness?			
Does the patient have any residual paralysis at 60 days after onset of paralysis?			
Is there residual sphincter dysfunction?			
Has your diagnosis changed since you originally notified this case?			

If NO, please give date of death

If NO, duration of paralysis? days

If YES, specify level Sensory Motor Both

Discharge date

FINAL DIAGNOSIS

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

Peripheral neuropathy

- Guillain-Barre syndrome (acute post-infectious polyneuropathy)

Anterior horn cell disease

- Acute poliomyelitis
- Vaccine-associated poliomyelitis
- Other neurotropic viruses
- Hopkins' syndrome

Systemic disease

- Acute porphyria
- Critical illness neuropathy/myopathy
- Conversion disorder

Disorders of neuromuscular transmission

- Botulism
- Insecticide *e.g. organophosphate poisoning*
- Tick bite paralysis
- Other (specify)

Acute myelopathy

- Transverse myelitis
- Acute disseminated encephalomyelitis (ADEM)
- Spinal cord ischaemia
- Spinal cord injury including trauma
- Peri-operative complication
- Other (specify)

Muscle disorders

- Periodic paralyses
- Mitochondrial diseases (infantile type)
- Viral myositis
- Drug-induced paralysis (specify)

Continued on next page

AFP Follow-Up Form V4.0 08/07/2016

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.

ACUTE FLACCID PARALYSIS QUESTIONNAIRE

FINAL DIAGNOSIS contd. From page 1

Other diagnosis not included above or overleaf

☐ Other, specify below in Comments box

Comments

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

Form completed by:_____ Position: _____

Contact telephone number:_____ Date of Completion |__|__|__|__|__|__|

Email:_____

Please Fax form to Dr. Suzanne Cotter, HPSC at Fax No. 01 8561299 and HPSC will then forward on to NVRL