ACUTE FLACCID PARALYSIS 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

Hospital:
Consultant:
Email:
Referring Hospital
Referring Consultant:

GP DETAILS

GP Name:
GP Tel:
GP Address
Email

CLINICAL FEATURES AND INVESTIGATIONS

	Yes	No	Unk	
Date of onset of paralysis (dd/mm/yy)				
Presence of fever at onset of paralysis				
Rapid progression of paralysis (within 14 days)				
Presence of asymmetric paralysis				
Was the patient hospitalised?				
Was the patient immunosuppressed?				If YES, specify
Was a sensory level detected on examination?				If YES, specify
Was there cranial nerve involvement?				If YES, specify
Was there bladder or bowel involvement? (incl. urinary retention/ incontinence)				If YES, specify

Site of paralysis?
Facial paralysis only
Limb
Limbs & resp. muscles (bulbar)
Bulbar only
Limb plus facial paralysis
Unknown

BioMed investigations and results

	Yes	No	Unk	
Was EMG performed?				If YES, specify results
If YES, Date:				
Were nerve conduction studies done?				If YES, specify results
If YES, Date:				
Was spinal MRI done?				If YES, specify results
If YES, Date:				

Other investigations and results

Please indicate if following tests done:	Yes	No	Unk	If YES, Date:
Throat swab?				
Nasopharyngeal swab/aspirate?				
Was a lumbar puncture (LP)?				

CSF Results:
No. of PMN
No. of Lymphocytes
No. of RBCs
Other
Glucose mmol/L
protein g/L

Results:
Throat
Nasopharyngeal

AFP 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.

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CLINICAL FEATURES AND INVESTIGATIONS contd.

Other investigations and results contd.

Number faecal specimens sent to NVRL for viral culture

☐ None
☐ One
☐ Two
☐ Unk

Date 1st faecal specimen _____

Result _____

Date 2nd faecal specimen _____

Result _____

>=24 hours after first specimen and both taken within 14 days of onset of paralysis

Was any causative/suspected pathogen or cause identified in case? Please specify below.

_____

PATIENT VACCINATION HISTORY (if known)

Has the patient ever been immunized against polio? Yes ☐ No ☐ Unk ☐

If YES, date of last polio vaccination? _____ Unk ☐

Vaccine Type	Oral:	IPV:	Vaccination Date	Brand	Batch Number
1st dose	☐	☐			
2nd dose	☐	☐			
3rd dose	☐	☐			
4th dose	☐	☐			

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

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

If YES to either question, specify who/where _____

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)

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) _____

Other diagnosis or any comments

_____

OUTCOME AT THE TIME OF REPORTING

Date of Follow-up _____

	Yes	No	Unk
Did the patient survive the illness?	☐	☐	☐
Does the patient have any residual paralysis?	☐	☐	☐
Is there residual sphincter dysfunction?	☐	☐	☐

If NO, please give date of death _____

If NO, duration of paralysis? _____ days

If YES, specify level: Sensory ☐ Motor ☐ Both ☐

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:_____ 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