Case Investigation Form for Acute Flaccid Paralysis (AFP) Case

Urgent Case (i.e. Clinically Polio):Y/N	Case Investigation Form for Acute Flaccid Paralysis (AFP) Case			
High Risk Population: Y/N OPV Doses<3	EPID NUMBER PAK/ / / /	Date of onset of weakness/paralysis	Date of Notification	Date of investigation

Identification

Patient's Name:		Sex:	Male	Female
Father's Name:	Caste:	Occupation:		
Grand Father's Name:	Age at the time of onset of paralysis/weakness (in months):			
Address: House No.	Street / Mohalla:			
Village/Moza:	Union Counci/Ward:			
Tehsil/City:	District:	Contact No:		

Notification

Notified by - Name&Designation:	Name of Health Facility/Unit:			
Is this a facility for: (encircle appropraite one) AS Site	ZR Site*	Outside network		
Type of source of reporting: (encircle appropraite one) Public/Armed Forces/Private/Informal health care provider/Community based				
Admitted: Yes / No	Date of Admission to Hospital/Health facility:	Day	Month	Year
Provisional diagnosis in Hospital:				
If the patient died, date of death		Day	Month	Year
Specify any prior weakness/paralysis, seizures or other neurologic disorders of patient				
Verify:	Is weakness/paralysis acute (sudden and rapid progression)?		Yes	No
	Is weakness/paralysis flaccid? (i.e. floppy)		Yes	No
If weakness/paralysis is not acute & flaccid, stop investigation. Specify diagnosis (if known)				
Was there fever at the onset of weakness/paralysis?		Yes	No	Unknown

Signs & Symptoms

Is the weakness/paralysis asymmetric ?			Yes	No	Unknown
How many days from the time of weakness/paralysis onset to full installation of weakness/paralysis?				______Days	Unknown
Site of Paralysis (please encircle all that apply)	Right leg	Left leg	Right arm	Left arm	
	Breathing muscles	Neck muscles	Facial muscles	If other: specify _________	
Where is the weakness/paralysis in arms?		Proximal	Distal	Both	Neither
Where is the weakness/paralysis in legs?		Proximal	Distal	Both	Neither

Neurological Examination		Right leg	Left leg	Right arm	Left arm
	Tone				
	Power				
	Reflexes				
	Sensation				

Health care provider(s) visited

1.____________________________ 2. _____________________________ 3. _____________________________

Travel History

Did patient travel from home with in 30 days before weakness/paralysis onset?				Yes	No
If yes, Places visited:	Villages / UC	Tehsil	District	Country	When & for how long

Immunization History

Number of OPV doses received during routine immunization (exclude 0 dose)	Doses	Unknown
Were the Routine doses verified by EPI card?	Yes	No
If yes, write Card Number and Name of the Centre:		
Number of additional OPV doses received during Immunization Campaigns/others?	Doses	Unknown
Number of OPVdoses received during last 6 vaccination rounds (Starting from the recent most) 1) Yes / No 2) Yes / No 3) Yes / No 4) Yes / No 5) Yes / No 6) Yes / No	Doses (total)	Unknown
Date of last OPV dose received: (before onset of Paralysis) Day: Month: Year:		
Date of last OPV dose received: (after onset of Paralysis) Day: Month: Year:		

Stool Specimen Collection & Dispatch

	Day:	Month:	Year:
Date of first stool specimen collection:	Day:	Month:	Year:
Date of first stool specimen sent to lab:	Day:	Month:	Year:
Date of second stool specimen collection:	Day:	Month:	Year:
Date of second stool specimen sent to lab:	Day:	Month:	Year:

Other AFP cases in the Locality

Are there other AFP cases in patient's community within 60 days of weakness/paralysis onset?	No	If yes, No. of Cases:
Name(s) and addresse(s) of other case/s found:		

Name of Investigating Doctor:	**Signatures:**
Name of attending Child Specialist/Physician:	**Signatures:**
Name of District/ Town Surveillance Coordinator:	**Signatures:**
Name of WHO Surveillance Officer:	**Signatures:**

*Zero reporting sites which are not active sites

Please retain a copy of this form for record at Hospital and District Health Office and send a copy to the Provincial Manager - EPI. Revised on 11/3/2010