



Poliomyelitis Investigation Form

		NBS ID
PATIENT	NAME (LAST, FIRST, M.I.)	ESTATE
	ADDRESS	CITY STATE ZIP CODE
Reporting Person	NAME	TELEPHONE
	ADDRESS	CITY STATE ZIP CODE

DEMOGRAPHICS

BIRTHDATE (MONTH/DAY/YEAR) _____	RACE <input type="checkbox"/> NATIVE AMER./ALASKAN NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> OTHER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> UNKNOWN	ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NOT HISPANIC <input type="checkbox"/> UNKNOWN
SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER <input type="checkbox"/> MALE <input type="checkbox"/> UNKNOWN		

CLINICAL DATA

DATE OF FIRST SYMPTOMS _____	CLINICAL DESCRIPTION OF ILLNESS (DATES, COURSE, ETC.) _____ _____ _____ _____
PRELIMINARY DIAGNOSIS <input type="checkbox"/> NONPARALYTIC POLIO <input type="checkbox"/> PARALYTIC POLIO	
TYPE OF PARALYSIS <input type="checkbox"/> BULBAR <input type="checkbox"/> SPINAL <input type="checkbox"/> BULBO-SPINAL	

LABORATORY - STATE LABORATORY

SPECIMENS FOR ISOLATION SUBMITTED
 YES NO

SPECIMEN TYPE	DATE OBTAINED	RESULT (TYPE)

SERUM SPECIMENS SUBMITTED
 YES NO

	TEST (NEUT. CF)	DATE OBTAINED	P1	P2	P3
SERUM 1					
SERUM 2					
SERUM 3					

CSF DATA	DATE	#WBC	% LYMPH	PROT	GLU
CSF 1					
CSF 2					
CSF 3					

LABORATORY - CDC LABORATORY

SPECIMENS FOR ISOLATION SENT <input type="checkbox"/> YES <input type="checkbox"/> NO		RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE RECEIVED		
SPECIMEN TYPE	DATE OBTAINED	RESULT (TYPE)			

STRAIN CHARACTERIZATION RESULTS
 VAN WEZEL OLIGONUCLEOTIDE

SERUM SPECIMENS SUBMITTED <input type="checkbox"/> YES <input type="checkbox"/> NO		RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE(S) RECEIVED		
	TEST (NEUT.)	DATE OBTAINED	P1	P2	P3
SERUM 1					
SERUM 2					
SERUM 3					
EMG	NERVE CONDUCT				

IMMUNOLOGIC STATUS

KNOWN IMMUNE DEFICIENCY <input type="checkbox"/> YES <input type="checkbox"/> NO	DESCRIBE
IMMUNE STUDIES <input type="checkbox"/> YES <input type="checkbox"/> NO	WHICH
RESULTS	

VACCINE HISTORY

INACTIVATED VACCINE (SALK) <input type="checkbox"/> NOT VACCINATED		ORAL VACCINATION (SABIN) <input type="checkbox"/> NOT VACCINATED	
DOSE	DATE OF VACCINATION	TYPE OF VIRUS	DATE OF VACCINATION
1		TYPE I	
2		TYPE II	
3		TYPE III	
4		TRIVALENT	
IF SALK INOCULATION WITHIN 30 DAYS PRIOR TO ONSET		IF ORAL VACCINATION WITHIN 30 DAYS PRIOR TO ONSET	
MFR	LOT NO.	MFR	LOT NO.
SITE OF INJECTION	SITE(S) OF 1ST PARALYSIS	HOUSEHOLD OR CLOSE CONTACT WITH ORAL VACCINE WITHIN PREVIOUS 60 DAYS <input type="checkbox"/> YES <input type="checkbox"/> NO	

EXPOSURE HISTORY

CASE/HH MEMBER TRAVEL TO ENDEMIC/EPIDEMIC AREA <input type="checkbox"/> YES <input type="checkbox"/> NO	WHO	WHERE	DATE(S)
CASE/HH MEMBER EXPOSURE TO PERSON(S) FROM OR RETURNING FROM ENDEMIC AREAS <input type="checkbox"/> YES <input type="checkbox"/> NO	WHO	WHERE	DATE(S)
CASE/HH CONTACT WITH KNOWN CASE <input type="checkbox"/> YES <input type="checkbox"/> NO	WHO	WHERE	DATE(S)
OPV RECIPIENT CONTACT <input type="checkbox"/> YES <input type="checkbox"/> NO			
HOUSEHOLD CONTACT <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE	AGE	RELATION
NON-HOUSEHOLD CONTACT <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE	AGE	
DATE CONTACT RECEIVED OPV	DOSE NUMBER	LOT NUMBER	

FOLLOW UP

CLINICAL STATUS 60 DAYS OR LONGER AFTER ONSET

- COMPLETE RECOVERY, NO RESIDUAL PARALYSIS
- MINOR INVOLVEMENT ONLY
- SIGNIFICANT DISABILITY
- SEVERELY DISABLED (BED, WHEELCHAIR, EXTENSIVE BRACING)

DEATH - DATE _____

CAUSE OF DEATH _____

NEVER ANY PARALYSIS (NONPARALYTIC)

FINAL CLASSIFICATION

- PARALYTIC POLIO WITH RESIDUAL PARALYSIS
- PARALYTIC POLIO, NO RESIDUAL PARALYSIS
- PARALYTIC DISEASE DUE TO OTHER AGENT

SPECIFY _____

ASEPTIC MENINGITIS DUE TO:

- POLIOVIRUS (NONPARALYTIC POLIO)
- ECHO
- COXSACKIE
- OTHER (SPECIFY) _____
- ASEPTIC MENINGITIS, UNKNOWN ETIOLOGY

OTHER FINAL DIAGNOSIS _____

INSTRUCTIONS

Please submit this form immediately after preliminary information has been obtained on a suspected case of poliomyelitis.

Subsequently, revised copies of this form should be submitted when additional information becomes available. The following information, usually obtained in epidemiologic investigations of poliomyelitis cases, should be included: (attach additional sheet if necessary).

- a. **Clinical History:** A brief narrative of history, physical signs, and clinical laboratory result, including peripheral white blood cell count and cerebrospinal fluid findings.
- b. **Travel History:** An itinerary of the patient's travel outside of city of residence during preceding 30 days; history of contact with travelers.
- c. **Poliovaccine Contact History:** Household or other close contact with a recipient of oral poliovaccine within 60 days prior to onset of illness; specify date and relationship of recipient; if recipient is not a household member, describe frequency of contact and dates of contact. Include available virologic data on contacts of patient.
- d. **Other:** Describe other recent or concurrent immunizations. For young infants, history of breast feeding and maternal history of vaccination or exposure to poliomyelitis should be described.

DATE CASE FIRST REPORTED TO STATE MONTH DAY YEAR	FORM COMPLETED BY	TELEPHONE ()	DATE FORM COMPLETED MONTH DAY YEAR
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