Washington State Department of Health

Poliomyelitis/AFM

County

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ ☐ Years ☐ Months

Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

☐ Classification pending ☐ Confirmed ☐ Investigation in progress ☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status

☐ Complete ☐ Complete – not reportable to DOH ☐ Unable to complete Reason _____ ☐ In progress

Dates: **Investigation start** __/__/__ Investigation complete __/__/__ Record complete __/__/__ **Case complete** __/__/__

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: ☐ Female ☐ Male ☐ Other ☐ Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Patient declined to respond ☐ Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race ☐ Amer Ind/AK Native (***specify***: ☐ Amer Ind ***and/or*** ☐ AK Native) ☐ Asian ☐ Black or African American ☐ Native HI/Pacific Islander (***specify***: ☐ Native HI ***and/or*** ☐ Pacific Islander) ☐ White ☐ Patient declined to respond ☐ Unk

Additional race information:

☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Asian Indian ☐ Bamar/Burman/Burmese ☐ Bangladeshi ☐ Bhutanese
☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Chinese ☐ Congolese ☐ Cuban ☐ Dominican ☐ Egyptian
☐ Eritrean ☐ Ethiopian ☐ Fijian ☐ Filipino ☐ First Nations ☐ Guamanian or Chamorro ☐ Hmong/Mong
☐ Indigenous-Latino/a or Indigenous-Latinx ☐ Indonesian ☐ Iranian ☐ Iraqi ☐ Japanese ☐ Jordanian ☐ Karen
☐ Kenyan ☐ Khmer/Cambodian ☐ Korean ☐ Kuwaiti ☐ Lao ☐ Lebanese ☐ Malaysian ☐ Marshallese ☐ Mestizo
☐ Mexican/Mexican American ☐ Middle Eastern ☐ Mien ☐ Moroccan ☐ Nepalese ☐ North African ☐ Oromo
☐ Pakistani ☐ Puerto Rican ☐ Romanian/Rumanian ☐ Russian ☐ Samoan ☐ Saudi Arabian ☐ Somali
☐ South African ☐ South American ☐ Syrian ☐ Taiwanese ☐ Thai ☐ Tongan ☐ Ugandan ☐ Ukrainian
☐ Vietnamese ☐ Yemeni ☐ Other: _____

What is your (your childs) preferred language? Check one:

☐ Amharic ☐ Arabic ☐ Balochi/Baluchi ☐ Burmese ☐ Cantonese ☐ Chinese (unspecified) ☐ Chamorro ☐ Chuukese
☐ Dari ☐ English ☐ Farsi/Persian ☐ Fijian ☐ Filipino/Pilipino ☐ French ☐ German ☐ Hindi ☐ Hmong ☐ Japanese
☐ Karen ☐ Khmer/Cambodian ☐ Kinyarwanda ☐ Korean ☐ Kosraean ☐ Lao ☐ Mandarin ☐ Marshallese ☐ Mixteco
☐ Nepali ☐ Oromo ☐ Panjabi/Punjabi ☐ Pashto ☐ Portuguese ☐ Romanian/Rumanian ☐ Russian ☐ Samoan
☐ Sign languages ☐ Somali ☐ Spanish/Castilian ☐ Swahili/Kiswahili ☐ Tagalog ☐ Tamil ☐ Telugu ☐ Thai ☐ Tigrinya
☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ Other language: _____ ☐ Patient declined to respond ☐ Unknown

Interpreter needed ☐ Yes ☐ No ☐ Unk

Case Name _____ LHJ Case ID _____

EMPLOYMENT AND SCHOOL

Employed ☐ Yes ☐ No ☐ Unk Occupation _____ Industry _____

Employer _____ Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk

Type of school ☐ Preschool/day care ☐ K-12 ☐ College ☐ Graduate School ☐ Vocational ☐ Online ☐ Other

School name _____ School address _____

City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____

OK to talk to patient (If Later, provide date) ☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___ ☐ Complete ☐ Partial ☐ Unable to reach ☐ Patient could not be interviewed

Alternate contact: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Friend ☐ Other _____

Name _____ Phone _____

Outbreak related ☐ Yes ☐ No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___

Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Y	N	Unk	
☐	☐	☐	Meets criteria for suspect Acute Flaccid Myelitis
☐	☐	☐	Has polio been adequately ruled out

Working diagnosis ☐ AFM ☐ Polio Polio type ☐ Paralytic ☐ Non paralytic

Final diagnosis ☐ AFM ☐ AFP ☐ Polio Polio type ☐ Paralytic ☐ Non paralytic

Clinical Features

Y	N	Unk	
☐	☐	☐	**Fever** If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	If no, Fever in 30 days prior to onset
☐	☐	☐	If no, Fever 48 hours prior to onset
☐	☐	☐	Bowel or bladder incontinence
☐	☐	☐	Cognitive defect
☐	☐	☐	Cranial nerves feature: diplopia, loss of sensation in face, facial droop, hearing loss, dysphagia, dysarthria
☐	☐	☐	Decreased or absent tendon reflexes in the affected limbs

Y	N	Unk	
☐	☐	☐	Fatigue
☐	☐	☐	Malaise
☐	☐	☐	**Headache**
☐	☐	☐	Invasive ventilator support
☐	☐	☐	**Myalgia (muscle aches or pain)**
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Altered mental state
☐	☐	☐	Sensory deficit
☐	☐	☐	Seizure new with disease
☐	☐	☐	**Nuchal rigidity (stiff neck)**
☐	☐	☐	Other apparent cause of paralysis (e.g., trauma to affected limb, spinal cord injury)
			Specify _____
☐	☐	☐	Pain or burning in the affected limbs
☐	☐	☐	Sensory level on torso (i.e., reduced sensation below a certain level of the torso)
☐	☐	☐	**Paralysis in one or more limbs**
☐	☐	☐	Acute onset Onset date ___/___/___
			Limbs affected ☐ Right arm ☐ Left arm ☐ Left Leg ☐ Right Leg
			Symmetry ☐ Symmetric ☐ Asymmetric ☐ Unk ☐ Other _____
			Nature of progression ☐ Ascending ☐ Descending ☐ Unk ☐ Other _____
			Follow-up assessment of status at 60 days or more after onset ☐ Done ☐ Not done ☐ Lost to follow-up
☐	☐	☐	If Done, Paralysis present 60 days or more after onset

Date of neurological exam ___/___/___

Predisposing Conditions

Y	N	Unk	
☐	☐	☐	Viral etiology identified Viral agent _____
☐	☐	☐	HIV positive/AIDS
☐	☐	☐	History of acute respiratory illness (30 days prior to onset)
☐	☐	☐	Received any immunosuppressing agents (30 days prior to onset) Specify _____

Y N Unk
☐ ☐ ☐ Immunosuppressive therapy or condition, or disease Specify ________________________________
☐ ☐ ☐ Injections received within 30 days prior to onset with date
Site of injection ______________________ Substance ________________________________
☐ ☐ ☐ Abnormal neurological history Specify ________________________________
☐ ☐ ☐ Any other underlying illness Specify ________________________________

Vaccination

Y N Unk
☐ ☐ ☐ Ever received polio containing vaccine Number of polio doses prior to illness _______
Vaccine information available ☐ Yes ☐ No

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

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Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Y N Unk
☐ ☐ ☐ Polio vaccination up to date for age per ACIP
Vaccine series not up to date reason
☐ Religious exemption ☐ Medical contraindication ☐ Philosophical exemption
☐ Laboratory confirmation of previous disease ☐ MD diagnosis of previous disease
☐ Underage for vaccine ☐ Parental refusal ☐ Other ___________________ ☐ Unknown

Y N Unk
☐ ☐ ☐ Received **any** vaccines within the 30 days prior to onset of symptoms
Describe ________________________________
☐ ☐ ☐ Received OPV within the 30 days prior to onset of symptoms
☐ ☐ ☐ Household member or close contact received OPV within the 90 days prior to onset of symptoms
Describe ________________________________

Physician Reporting/Patient Health Care

Date of follow-up ___/___/___
Outcome ☐ Fully recovered ☐ Partial recovery with residual paralysis ☐ Outcome pending ☐ Fatal ☐ Unk
If partial recovery
Site of paralysis ☐ Spinal ☐ Bulbar ☐ Spino-bulbar ☐ Specific sites ________________________________
Severity of paralysis at follow-up ☐ Minor (any minor involvement) ☐ Significant ($\leq$ 2 extremities, major involvement)
☐ Severe ($\geq$ 3 extremities and respiratory involvement) ☐ Unk

Y N Unk
☐ ☐ ☐ Specimens sent to CDC for testing
Type ☐ NP swab ☐ OP swab ☐ Rectal swab ☐ Stool ☐ Whole blood ☐ Serum ☐ CSF
☐ Other ________________________________

Hospitalization

Y N Unk
☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ________________________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ____________________
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Mechanical ventilation or intubation required
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk
☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*

Y N Unk

☐ ☐ ☐ Autopsy performed

☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition

Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital ☐ Emergency department (ED)
☐ Inpatient ward ☐ ICU ☐ Other _____

RISK AND RESPONSE (Ask about exposures 3-35 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Y N Unk

☐ ☐ ☐ Household member or close contact travelled to, or reside in, another country (30 days prior to onset)
Describe _____

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____

☐ ☐ ☐ Contact with recent foreign arrival Country _____ Date(s) of contact ___/___/___

☐ ☐ ☐ Contact with recent OPV vaccinee

☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter
☐ Other _____

Water Exposure

Y N Unk **Describe**

☐ ☐ ☐ Source of drinking water known
☐ ☐ ☐ Bottled water _____
☐ ☐ ☐ Public water system _____
☐ ☐ ☐ Individual well _____
☐ ☐ ☐ Shared well _____
☐ ☐ ☐ Other _____

☐ ☐ ☐ Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) _____

☐ ☐ ☐ Recreational water exposure (e.g., lake, river, pool, waterpark) _____

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ Epidemiologically linked to a lab positive case classified as confirmed

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____
☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Foodborne ☐ Waterborne ☐ Person to person ☐ Unk ☐ Other _____
Describe _____

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship
☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit
☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Exposure summary

Suspected transmission type (check all that apply) ☐ Foodborne ☐ Waterborne ☐ Person to person ☐ Unk
☐ Other _____
Describe _____

Case Name _____ LHJ Case ID _____

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other_____
Describe _____

Public Health Issues (Polio only)

Evaluated immune status of close contacts ☐ Yes Date initiated ___/___/___
Number of close contacts evaluated for immune status _____
Number of susceptible contacts identified _____
☐ No, close contacts not evaluated
☐ No, case had no close contacts
☐ Unk

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions (Polio only)

Y N Unk

☐ ☐ ☐ Prophylaxis of appropriate contacts recommended Date initiated ___/___/___
Number of contacts recommended prophylaxis _____
Number of contacts receiving prophylaxis _____
Number of contacts completing prophylaxis _____
☐ ☐ ☐ Public announcement recommended
☐ ☐ ☐ Strict isolation for incubation period
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action _____

TRANSMISSION TRACKING (Polio only)

Contagious period: 1 week prior to symptom onset, 6 weeks after symptom onset

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk

Settings and details (check all that apply)
☐ Day care ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Health care ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

NOTES

LAB RESULTS

Lab report information
Lab report reviewed – LHJ ☐
WDRS user-entered lab report note

Submitter _____
Performing lab for entire report _____
Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date ___/___/___ Specimen received date ___/___/___
WDRS specimen type _____
WDRS specimen source site _____
WDRS specimen reject reason _____

Test performed and result
WDRS test performed _____
WDRS test result, coded _____
WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____
WDRS unit of measure _____
Test method _____
WDRS interpretation code _____
Test result – Other, specify _____
WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
Upload document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____

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