



Poliomyelitis

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 _____ LHM Case ID (optional) _____

LHM 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 _____ LHM _____
 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 child's) 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

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 _____ °F
 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 _____
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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 (≤ 2 extremities, major involvement)
 Severe (≥ 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:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> 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 _____

- 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)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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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