

Suspected Polio Case Worksheet

REPORT CONTACT

Name (Last, First), Initial Report Date, Address, City, County, State, Zip Code, Phone, Reporting Laboratory, State

PATIENT IDENTIFIERS

Name (Last, First), Birth Date, City, County, State, Occupation, Age at Onset, Age Type, Ethnicity, Race, Sex, Date of Onset of First Symptoms, Date of Onset of Paralysis

CLINICAL COURSE

Clinical Course

CSF RESULTS

Date, WBCs, RBCs, % Lymph, % Polys, Protein, Glucose

OUTCOME

Date of 60-day Follow Up, Sites of Paralysis, Specific Sites, 60-day Residual, Date of Death

IMMUNIZATION HISTORY

TOPV within 30 Days Prior to Onset of Symptoms?, Date, Lot Number

VACCINE DATE 1 DATE 2 DATE 3, IPV-containing, TOPV, BOPV, MOPV, Total Doses Ever Received, Lot Number, Type

CS210384-A

INJECTIONS RECEIVED WITHIN 30 DAYS PRIOR TO ONSET OF ILLNESS

Date of First Injection <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Substance of First Injection <input type="text"/>	Describe _____ _____	Site of First Injection <input type="text"/>	Substance of Injection 1 = Vaccine 2 = Antibiotic 3 = Other Site of Injection 1 = Left Deltoid 2 = Right Deltoid 3 = Left Thigh 4 = Right Thigh 5 = Left Gluteal 6 = Right Gluteal
Date of Second Injection <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Substance of Second Injection <input type="text"/>	Describe _____ _____	Site of Second Injection <input type="text"/>	
Date of Third Injection <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Substance of Third Injection <input type="text"/>	Describe _____ _____	Site of Third Injection <input type="text"/>	
Date of Fourth Injection <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Substance of Fourth Injection <input type="text"/>	Describe _____ _____	Site of Fourth Injection <input type="text"/>	

EXPOSURE HISTORY

Did Case/Household Member Travel to Endemic/Epidemic Area(s)? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No	Location(s) of Exposure _____ _____	Date of Departure <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Date of Return <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Was Case/Household Member Exposed to Person(s) from or Returning to Endemic Areas? <input type="checkbox"/>	Location(s) of Exposure _____ _____	Date of Departure <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Date of Return <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Did Case/Household Member have Contact with Known Case? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No	Contact Name (Last) _____ (First) _____	Location of Exposure _____	Date of Contact <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Did Case have Contact with OPV Recipient? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No	If "Yes"; Date of Contact with Household OPV Recipient <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year Relation _____	Age <input type="text"/> <input type="text"/> <input type="text"/> 999 = Unknown	Age Type <input type="text"/>
	If "Yes"; Date of Contact with Nonhousehold OPV Recipient <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year Relation _____	Age <input type="text"/> <input type="text"/> <input type="text"/> 999 = Unknown	Age Type <input type="text"/>
Date Contact Received OPV <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Dose Number _____	Lot Number _____	Age Type 0 = 0-120 Years 1 = 0-11 Months 2 = 0-52 Weeks 3 = 0-28 Days 9 = Age Unknown

LABORATORY INFORMATION

STATE OR LOCAL LABORATORY	SERUM SPECIMENS SUBMITTED				SPECIMENS SUBMITTED FOR ISOLATION			
	Laboratory Name _____				SPECIMEN 1			
	SERUM 1 P1, P2, or P3 <input type="checkbox"/> 1 = P1 <input type="checkbox"/> 2 = P2 <input type="checkbox"/> 3 = P3	Test <input type="checkbox"/> 1 = Neut. <input type="checkbox"/> 2 = CF	Result _____	Date Drawn/Obtained <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Results _____	Laboratory Name _____	Specimen Type _____	Date Drawn/Obtained <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
	SERUM 2 P1, P2, or P3 <input type="checkbox"/> 1 = P1 <input type="checkbox"/> 2 = P2 <input type="checkbox"/> 3 = P3	Test <input type="checkbox"/> 1 = Neut. <input type="checkbox"/> 2 = CF	Result _____	Date Drawn/Obtained <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	Results _____	Laboratory Name _____	Specimen Type _____	Date Drawn/Obtained <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year

LABORATORY INFORMATION (Continued)

CDC LABORATORY

SERUM SPECIMENS SENT TO CDC

SPECIMENS FOR POLIO VIRUS ISOLATION SENT TO CDC

SERUM 1

P1, P2, or P3

Test

Result

Date Drawn/Obtained

1 = P1
 2 = P2
 3 = P3

1 = Neut.
 2 = CF

Month Day Year

SERUM 2

P1, P2, or P3

Test

Result

Date Drawn/Obtained

1 = P1
 2 = P2
 3 = P3

1 = Neut.
 2 = CF

Month Day Year

SPECIMEN 1

Specimen Type

Results (Viral Type)

Strains (Characterization Results)

Date Received

1 = Oligo-nucleotide
 2 = Genomic Sequencing
 3 = Polymerase Chain Reaction

Month Day Year

Date Obtained

Month Day Year

SPECIMEN 2

Specimen Type

Results (Viral Type)

Strains (Characterization Results)

Date Received

1 = Oligo-nucleotide
 2 = Genomic Sequencing
 3 = Polymerase Chain Reaction

Month Day Year

Date Obtained

Month Day Year

EMG Conducted?

1 = Yes
 2 = No

EMG Results

Date of EMG

Month Day Year

Nerve Conduction?

1 = Yes
 2 = No

Nerve Results

Date Nerve Conduction

Month Day Year

Immune Deficiency Diagnosed Prior to OPV Exposure?

1 = Yes
 2 = No
 3 = Other

Diagnosis _____

Immune Studies Performed

HIV Status

1 = Positive
 2 = Negative
 9 = Unknown

ADDITIONAL COMMENTS