PAPUA NEW GUINEA DISEASE SURVEILLANCE SYSTEM
Acute Flaccid Paralysis (AFP) Case Investigation Form

Date of Report/notification to district/province: _____ Date of Investigation:_____ EPID NO: _____

Investigator's Name: _____ Health facility:_____ District : _____ Province:_____

1. Case Identification

Patients Name: ____ _____ _____ Sex: Male/Female Age: Years _____ Months_____ Date of Birth: dd/mm/yy

Mothers Name: _____ **Father's Name: _____**

Permanent Address: **Village/LLG:**_____ **District:** **Province:**

Street/Landmark: **Family's phone number:**

2. Travel history

Did the patient tarvel during the 30 days before paralysis onset? **Yes/No** If yes, list places visited and dates of visit in each place:

Place/ dates of visit: _____

3. Immunization History

of OPV doses:_____ # of IPV doses_____ Total Doses of OPV + IPV: _____ **Date of Last vaccination : dd/mm/yy**

4.Clinical Examination for AFP *[please use back page if space insufficient]*

Place of Examination: _____ **Examiner's Name:** _____

Date of onset of paralysis: dd/m/yy Date of onset of symptons: dd/mm/yy

Number of days from onset to maximum paralysis: _____

Site of Paralyss (circle): *right arm / left arm / right leg / left leg / other (describe):*

Fever	**Y N U**	Acute paralysis	**Y N U**	Meningeal signs	**Y N U**
Muscle pains	**Y N U**	Flaccid paralysis	**Y N U**	Upper motor neuron signs	**Y N U**
Headache	**Y N U**	Asymmetrical paralysis	**Y N U**	Sensation loss	**Y N U**
Seizures	**Y N U**	Ascending paralysis	**Y N U**	Muscles tone (provide grading)	_____
Injections (< 30 days)	**Y N U**	Deep Tendon reflexes (DTR) normal, reduced, absent, increased			

Other symptoms:

Results of Clinical tests, particularly CSF:

Clinical working diagnosis

Does the patient have AFP? ***Yes / No***

If not AFP: injury / spastic paralysis / old polio / other describe:

Place of examination: _____ **Examiners Signature:** _____

Hospitalized? **Yes/ No** **Hospital name:**_____ **Hospital ID:**_____ Date of Admission: / / Date of discharge: / /

Before coming to this facility, did the patient seek care in other places (example district hospital, private clinic, traditional healer)? **Yes/No**

Name of facility: _____ **Date of visit: / /** **Type of facility:** health center/ private clinic/traditional healer/other _____

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5. Stool specimen collection

Stool 1 Date of stool collection: dd/mm/yy **Date stool sent to CPHL:** **Date stool received in CPHL:** Date specimen sent to VIDRL: / /

Stool 2 Date of stool collection: **Date stool sent to CPHL:** **Date stool received in CPHL:** Date specimen sent to VIDRL: / /

Laboratory results received: dd/mm/yy Findings:

6. Stool Collection from contacts

Stools collected from contacts for this case? **Yes / No** **If yes, how many contact stools were collected?** _____

7. 60-Day Follow-up Exam (to be done if case is inadequate)

Date of follow up exam: dd/mm/yy **Examiners signature:** _____

Results of exam (circle): No residual paralysis/ Residual paralysis / lost to follow up/ died / no follow up

If follow-up exam not done, explain reason: Child died/ Family not found/ Examiner did not conduct visit

Comments: