# Poliomyelitis

Agency:

Investigator: Phone number:

**FOR STATE USE ONLY**
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

## CASE

Last name: First and middle name: Maiden name: Suffix: Address line: Zip: City: State: County: Phone: ( )- - Type: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name:

Date of Birth: / / Estimated? ☐ Age:

Gender: ☐ Female ☐ Male ☐ Other

Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed

Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Parent/Guardian name:

Parent/Guardian phone: ( )- - Type:

## EVENT

Diagnosis date: / / Onset date: / /

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name:

Exposure setting:

Epi-linked: ☐ Yes ☐ No ☐ Unknown

Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown

State: Country:

**Healthcare provider information**

Last name:

First name:

Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name:

Address line 1:

Address line 2:

Zip code: City:

State: County:

Phone : ( )- - Type:

## LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Result date: / /

Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative

Organism: **Poliovirus** Type:

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Result date: / /

Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative

Organism: **Poliovirus** Type:

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Result date: / /

Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative

Organism: **Poliovirus** Type:

## OCCUPATIONS

**Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.**

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

## HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Admission date: / / Discharge date: / / Days hospitalized: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Admission date: / / Discharge date: / / Days hospitalized: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

## CLINICAL INFO & DIAGNOSIS

**Symptoms**

**Paralysis:** ☐ Yes ☐ No ☐ Unk Onset date: / / Paralysis sites: _____

Fever ☐ Yes ☐ No ☐ Unk
Headache ☐ Yes ☐ No ☐ Unk
Muscle pain ☐ Yes ☐ No ☐ Unk
Nausea ☐ Yes ☐ No ☐ Unk
Paralysis ☐ Yes ☐ No ☐ Unk
Stiff neck ☐ Yes ☐ No ☐ Unk
Trouble swallowing ☐ Yes ☐ No ☐ Unk
Vomiting ☐ Yes ☐ No ☐ Unk

**Tensilon test performed:** ☐ Yes ☐ No ☐ Unk
Date of test: / /
Results: ☐ Positive ☐ Equivocal ☐ Negative ☐ Unknown

**EMG performed:** ☐ Yes ☐ No ☐ Unk
Date of test: / /
Results compatible with polio: ☐ Yes ☐ No ☐ Unk

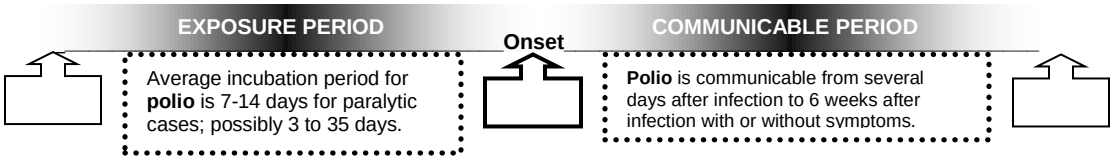
**Nerve conduction test performed:** ☐ Yes ☐ No ☐ Unk
Date of test: / /
Result:

**60-day residual symptoms:** ☐ Yes ☐ No ☐ Unk

Fever ☐ Yes ☐ No ☐ Unk
Headache ☐ Yes ☐ No ☐ Unk
Muscle pain ☐ Yes ☐ No ☐ Unk
Nausea ☐ Yes ☐ No ☐ Unk
Paralysis ☐ Yes ☐ No ☐ Unk
Stiff neck ☐ Yes ☐ No ☐ Unk
Trouble swallowing ☐ Yes ☐ No ☐ Unk
Vomiting ☐ Yes ☐ No ☐ Unk

## INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.




## RISK FACTORS/TRAVEL

**Vaccinated for Polio?** ☐ Yes ☐ No ☐ Unknown

| | | | | | |
|---|---|---|---|---|---|
| Date vaccinated: | / / | Date vaccinated: | / / | Date vaccinated: | / / |
| Lot #: | | Lot #: | | Lot #: | |
| Vaccine type: | | Vaccine type: | | Vaccine type: | |
| Manufacturer: | | Manufacturer: | | Manufacturer: | |

**Number of vaccinations:** ____

***In the 35 days prior to the onset of symptoms did the case:***

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: _____ — Departure date: / / — Return date: / /

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk — State: _____ City: _____ — Departure date: / / — Return date: / /

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: _____ — Departure date: / / — Return date: / /

Exposed to potential cases: ☐ Yes ☐ No ☐ Unk — Country outside U.S.: _____ — From date: / / — To date: / /

**Work with a case:** ☐ Yes ☐ No ☐ Unk — From date: / / — To date: / /

**Lived with another case:** ☐ Yes ☐ No ☐ Unk — From date: / / — To date: / /

**Contact w/t OPV recipient:** ☐ Yes ☐ No ☐ Unk — Lived w/t recipient: ☐ Yes ☐ No ☐ Unk — Age of recipient: _____

Recipient relationship: ☐ Child care contact ☐ Close contact not living in household ☐ Household

## CONTACTS

**Number of people living in case's household:** ____

***Close contacts with similar symptoms***

| Name | DOB | Gender | Address/Phone |
|---|---|---|---|
| | / / | ☐ Male ☐ Female | Zip code: Phone: - - |

| Relationship to case | | List symptoms | Symptom onset date | Is contact a case? |
|---|---|---|---|---|
| ☐ Spouse<br>☐ Child<br>☐ Sibling<br>☐ Roommate<br>☐ Parent/ guardian | ☐ Sexual contact<br>☐ Family member (non-household)<br>☐ Friend/acquaintance<br>☐ Contact- work/school/etc<br>☐ Unknown/Other | | / / | ☐ Yes<br>☐ No |

*If this contact is a case create a new event and/or case for this contact.*

| Name | DOB | Gender | Address/Phone |
|---|---|---|---|
| | / / | ☐ Male ☐ Female | Zip code: Phone: - - |

| Relationship to case | | List symptoms | Symptom onset date | Is contact a case? |
|---|---|---|---|---|
| ☐ Spouse<br>☐ Child<br>☐ Sibling<br>☐ Roommate<br>☐ Parent/ guardian | ☐ Sexual contact<br>☐ Family member (non-household)<br>☐ Friend/acquaintance<br>☐ Contact- work/school/etc<br>☐ Unknown/Other | | / / | ☐ Yes<br>☐ No |

*If this contact is a case create a new event and/or case for this contact.*

NOTES: _____