

**North Carolina Department of Health and Human Services  
Division of Public Health • Epidemiology Section  
Communicable Disease Branch**



**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department  
Communicable Disease Control  
414 East Main Street  
Durham, NC 27701

Telephone: (919) 560-7600  
Fax: (919) 560-7716

**POLIOMYELITIS, PARALYTIC**  
Confidential Communicable Disease Report—Part 2  
NC DISEASE CODE: 30

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

**NC EDSS LAB RESULTS**

Diagnostic testing for poliomyelitis is complicated and may need to be sent to CDC for testing. Please call the NC State Immunization Branch at 919-707-5550 immediately if you think you may have a case of polio. Labs results can be entered or attached to the event later—once results are completed.

**NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE**

**Is/was patient symptomatic for this disease?**  Y  N  U  
**If yes, symptom onset date (mm/dd/yyyy):** \_\_\_/\_\_\_/\_\_\_

**CHECK ALL THAT APPLY:**

**Fever**  Y  N  U  
 Yes, subjective  No  
 Yes, measured  Unknown  
 Highest measured temperature \_\_\_\_\_  
 Fever onset date (mm/dd/yyyy): \_\_\_\_\_

**Was the fever recurring, remittent, or intermittant?**  Y  N  U  
**Fatigue or malaise or weakness**  Y  N  U  
**Did the patient have any immunity studies performed?**  Y  N  U  
 Please specify: \_\_\_\_\_

**Headache**  Y  N  U  
**Stiff neck**  Y  N  U  
**Meningitis**  Y  N  U  
**Cranial nerve or bulbar weakness or paralysis**  Y  N  U  
 Please specify: \_\_\_\_\_

**Difficulty swallowing (dysphagia)**  Y  N  U  
**Muscle paralysis**  Y  N  U  
**Acute flaccid paralysis**  Y  N  U  
 Onset date (mm/dd/yyyy): \_\_\_\_\_  
 Asymmetric  
 Symmetric

**Pseudoparalysis**  Y  N  U  
**Respiratory paralysis**  Y  N  U  
 Onset date (mm/dd/yyyy): \_\_\_\_\_

**Paralysis**  Y  N  U  
 Site:  
 Spinal  
 Bulbar  
 Spino-bulbar  
 Specific site \_\_\_\_\_

**Muscle aches / pains (myalgias)**  Y  N  U  
**EMG performed**  Y  N  U  
 Date performed (mm/dd/yyyy): \_\_\_\_\_  
 Result: \_\_\_\_\_

**Nerve conduction study performed**  Y  N  U  
 Date performed \_\_\_\_\_  
 Result \_\_\_\_\_

**Nausea**  Y  N  U  
**Vomiting**  Y  N  U  
**Other symptoms, signs, clinical findings, or complications consistent with this illness?**  Y  N  U  
 If yes, specify: \_\_\_\_\_

**Any immunosuppressive conditions?**  Y  N  U  
 Specify \_\_\_\_\_

**PREGNANCY**  
**Is the patient currently pregnant?**  Y  N  U  
 Estimated delivery date (mm/dd/yyyy): \_\_\_\_\_  
 Give number of weeks gestation at onset of illness: \_\_\_\_\_

**Has the mother received prenatal care?**  Y  N  U  
 Date of first prenatal visit (mm/dd/yyyy): \_\_\_\_\_  
 Number of prenatal visits: \_\_\_\_\_  
 Prenatal provider name \_\_\_\_\_  
 OB Name \_\_\_\_\_  
 Street address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Zip code \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_

**Did patient attend family planning clinic prior to conception?**  Y  N  U  
**Has the patient ever been pregnant?**  Y  N  U  
 Total number of previous pregnancies of the biologic mother: \_\_\_\_\_

**Was patient hospitalized for this illness >24 hours?**  Y  N  U  
 Hospital name: \_\_\_\_\_  
 City, State: \_\_\_\_\_

Hospital contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Admit date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Discharge date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

**CLINICAL OUTCOMES**  
**Discharge/Final diagnosis:** \_\_\_\_\_

**Survived?**  Y  N  U  
**Date of 60 day follow-up (mm/dd/yyyy):** \_\_\_\_\_  
**Paralysis?**  Y  N  U  
 Site:  
 Spinal  
 Bulbar  
 Spino-bulbar  
 Specific site: \_\_\_\_\_

**60-day residual:**  
 None  
 Minor (any minor involvement)  
 Significant (≤ 2 extremities, major involvement)  
 Severe (≥ 3 extremities and □ respiratory involvement)  
 Unknown

**Died?**  Y  N  U  
**If yes:**  
 Died from this illness?  Y  N  U  
 Death date (mm/dd/yyyy): \_\_\_\_\_  
 Autopsy performed?  Y  N  U  
 Source of death information (select all that apply):  
 Death certificate  
 Autopsy report final conclusions  
 Hospital/physician discharge summary  
 Other: \_\_\_\_\_  
*Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.*  
 Cause of death listed on death certificate: \_\_\_\_\_

(CONTINUED)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

**NC EDSS PART 2 WIZARD**  
**COMMUNICABLE DISEASE (CONTINUED)**

**TRAVEL**

**The patient is:**

- Resident North Carolina
- Resident of another state or US territory
- Foreign visitor
- Refugee
- Refugee camp(s)? .....  Y  N  U
- Name of camp \_\_\_\_\_
- Location of camp \_\_\_\_\_
- Country of birth \_\_\_\_\_
- Last country prior to arrival in US \_\_\_\_\_
- Date of entry to US \_\_\_\_\_
- Recent immigrant
- Country of birth \_\_\_\_\_
- Last country prior to arrival in US \_\_\_\_\_
- Date of entry to US \_\_\_\_\_
- Foreign adoptee
- Country of birth \_\_\_\_\_
- Last country prior to arrival in US \_\_\_\_\_
- Date of entry to US \_\_\_\_\_
- None of the above

**Did patient have a travel history during the 35 days prior to onset of symptoms until 6 weeks after onset of illness?** .....  Y  N  U

Travel dates: From: \_\_\_\_\_ until \_\_\_\_\_  
To city: \_\_\_\_\_ State: \_\_\_\_\_  
To country: \_\_\_\_\_

**Reason(s) for travel:**

- Vacation / tourism
- Organized tour
- Business related, specify \_\_\_\_\_
- Military related
- Visit to family / friends
- Peace corps
- Airline / Ship crew
- Missionary or dependent
- Refugee / Immigrant
- Student / Teacher
- Unknown
- Other \_\_\_\_\_

**Mode(s) of transportation (check all that apply)**

- Airplane
- Ship / boat / ferry
- Cruise ship? .....  Y  N  U
- Specify cruise line \_\_\_\_\_
- Train / subway
- On foot
- Bus/taxi/shuttle
- Automobile / motorcycle
- Other, specify: \_\_\_\_\_

**Did patient have contact with a person with travel history during the period of interest?** .....  Y  N  U

Contact's name: \_\_\_\_\_  
Travel dates: From: \_\_\_\_\_ until \_\_\_\_\_  
To city: \_\_\_\_\_  
To state: \_\_\_\_\_  
To country: \_\_\_\_\_

**Is contact a:**

- Resident of another state or US territory
- Foreign visitor
- Recent immigrant
- Refugee
- Foreign adoptee
- Unknown
- Other, specify: \_\_\_\_\_

**Does the patient know anyone else with similar symptoms?** .....  Y  N  U

If yes, specify name and relationship to person(s): \_\_\_\_\_

**Is the patient part of an outbreak of this disease?** .....  Y  N

**VACCINE**

**Has patient / contact ever received vaccine for this disease?** .....  Y  N  U

**Date of vaccination #1** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown  
Dose administered: \_\_\_\_\_  
Vaccine type: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_  
Product/trade name: \_\_\_\_\_  
Lot number: \_\_\_\_\_

**Date of vaccination #2** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown  
Dose administered: \_\_\_\_\_  
Vaccine type: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_  
Product/trade name: \_\_\_\_\_  
Lot number: \_\_\_\_\_

**Date of vaccination #3** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown  
Dose administered: \_\_\_\_\_  
Vaccine type: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_  
Product/trade name: \_\_\_\_\_  
Lot number: \_\_\_\_\_

**Date of vaccination #4** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown  
Dose administered: \_\_\_\_\_  
Vaccine type: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_  
Product/trade name: \_\_\_\_\_  
Lot number: \_\_\_\_\_

**Date of vaccination #5** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown  
Dose administered: \_\_\_\_\_  
Vaccine type: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_  
Product/trade name: \_\_\_\_\_  
Lot number: \_\_\_\_\_

**If yes, number of doses received prior to illness:** \_\_\_\_\_

**If no, reason for inadequate vaccination:**

- Religious exemption
- Medical exemption
- Medical contraindication
- Philosophical exemption (outside NC only)
- Laboratory evidence of previous disease
- Physician diagnosis of previous disease
- Under age for vaccination
- Parental refusal
- Missed opportunities
- Unknown
- Other, specify: \_\_\_\_\_

**Total number of simultaneous injections at the time of polio vaccination:** \_\_\_\_\_

**Injection(s) 30 days prior to illness onset:**

**First vaccine injection (mm/dd/yyyy):** \_\_\_\_\_  
**Injection site:**  
 Left deltoid       Right thigh  
 Right deltoid       Left gluteal  
 Left thigh           Right gluteal

**Second vaccine injection (mm/dd/yyyy):** \_\_\_\_\_

**Injection site:**  
 Left deltoid       Right thigh  
 Right deltoid       Left gluteal  
 Left thigh           Right gluteal

**Third vaccine injection (mm/dd/yyyy):** \_\_\_\_\_

**Injection site:**  
 Left deltoid       Right thigh  
 Right deltoid       Left gluteal  
 Left thigh           Right gluteal

**Fourth vaccine injection (mm/dd/yyyy):** \_\_\_\_\_

**Injection site:**  
 Left deltoid       Right thigh  
 Right deltoid       Left gluteal  
 Left thigh           Right gluteal

**Source of vaccine information:**

- Patient's or Parent's verbal report
- Physician
- Medical record (Note: Any vaccine on a medical record should be recorded in the NCIR)
- Certificate of immunization record (Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)
- Patient vaccine record
- School record
- Other, specify: \_\_\_\_\_
- Unknown
- NCIR

**Did patient have contact with OPV recipient?** .....  Y  N  U

Date(s) of contact: \_\_\_\_\_

**Did patient have contact with IPV recipient?** .....  Y  N  U

First date contact received IPV: \_\_\_\_\_  
Second date contact received IPV: \_\_\_\_\_  
Third date contact received IPV: \_\_\_\_\_  
Fourth date contact received IPV: \_\_\_\_\_  
Lot number of most recent dose: \_\_\_\_\_

**REASON FOR TESTING**

**Why was the patient tested for this condition?**

- Symptomatic of disease
- Screening of asymptomatic person with reported risk factor(s)
- Exposed to organism causing this disease (asymptomatic)
- Household / close contact to a person reported with this disease
- Other, specify \_\_\_\_\_
- Unknown

**PREDISPOSING CONDITIONS**

**HIV/AIDS** .....  Y  N  U

**Immunosuppressive conditions (not including HIV/AIDS)** .....  Y  N  U

**Other underlying illness** .....  Y  N  U

Please specify: \_\_\_\_\_

**Was the patient receiving any of the following treatments or taking any medications?**

**Antibiotics** .....  Y  N  U

For what medical condition? \_\_\_\_\_

**Chemotherapy** .....  Y  N  U

If yes, was therapy within the last 30 days before this illness? .....  Y  N  U

For what medical condition? \_\_\_\_\_

.....CONTINUED

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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**PREDISPOSING CONDITIONS CONTINUED**

Radiotherapy.....Y N U  
 If yes, was therapy within the last 30 days before this illness?.....Y N U  
 For what medical condition?  
 \_\_\_\_\_

Systemic steroids/corticosteroids, including steroids taken by mouth or injection.....Y N U  
 If yes, was medication taken within the last 30 days before this illness?.....Y N U  
 For what medical condition?  
 \_\_\_\_\_

Immunosuppressive therapy, including anti-rejection therapy.....Y N U  
 If yes, specify: \_\_\_\_\_  
 If yes, was medication taken within the last 30 days before this illness?.....Y N U  
 For what medical condition?  
 \_\_\_\_\_

Aspirin or aspirin-containing product.....Y N U  
 If yes, specify: \_\_\_\_\_  
 If yes, was medication taking within the last 30 days before this illness?.....Y N U  
 For what conditions?:  
 \_\_\_\_\_

**ISOLATION/QUARANTINE/CONTROL MEASURES**

**Restrictions to movement or freedom of action?**.....Y N  
 Check all that apply:  
 Work  Sexual behavior  
 Child care  Blood and body fluid  
 School  Other, specify \_\_\_\_\_

Date control measures issued: \_\_\_\_\_  
 Date control measures ended: \_\_\_\_\_  
 Was patient compliant with control measures?.....Y N

**Local health director or designee implement additional control measures?** (example: cohort classrooms, special cleaning, active surveillance, etc.).....Y N  
 If yes, specify: \_\_\_\_\_

**Were written isolation orders issued?**.....Y N  
 If yes, where was the patient isolated? \_\_\_\_\_  
 \_\_\_\_\_

Date isolation started? \_\_\_\_\_  
 Date isolation ended? \_\_\_\_\_  
 Was the patient compliant with isolation?.....Y N

**Were written quarantine orders issued?**.....Y N  
 If yes, where was the patient quarantined?  
 \_\_\_\_\_

Date quarantine started? \_\_\_\_\_  
 Date quarantine ended? \_\_\_\_\_  
 Was the patient compliant with quarantine?.....Y N

**Notes:**

**CHILD CARE/SCHOOL/COLLEGE**

**Patient in child care?**.....Y N U  
 Name of care provider: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip code: \_\_\_\_\_ County: \_\_\_\_\_  
 Contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Patient a child care worker or volunteer in child care?**.....Y N U  
 Name of child care provider: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip code: \_\_\_\_\_ County: \_\_\_\_\_  
 Contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Patient a parent or primary caregiver of a child in child care?**.....Y N U  
 Name of child care provider: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip code: \_\_\_\_\_ County: \_\_\_\_\_  
 Contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Is patient a student?**.....Y N U  
 Type of school:  
 NC Public School (preK-12)  
 NC Private School (preK-12)  
 Other School (preK-12)  
 Community College/College/University  
 Other academic institution (i.e. trade school, professional school, etc)  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip code: \_\_\_\_\_ County: \_\_\_\_\_  
 Contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_  
 Specify grade: \_\_\_\_\_

**Is patient a school WORKER / VOLUNTEER in NC school setting?**.....Y N U  
 Type of school  
 NC Public School (preK-12)  
 NC Private School (preK-12)  
 Other School (preK-12)  
 Community College/College/University  
 Other academic institution (i.e. trade school, professional school, etc)  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip code: \_\_\_\_\_ County: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Notes:**

**BEHAVIORAL RISK & CONGREGATE LIVING**

**During the 35 days prior to onset of symptoms until 6 weeks after onset of illness did the patient live in any congregate living facilities** (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)?.....Y N U  
 Name of facility: \_\_\_\_\_  
 Dates of contact: \_\_\_\_\_

**During the 35 days prior to onset of symptoms until 6 weeks after onset of illness, did the patient attend social gatherings or crowded settings?**.....Y N U  
 If yes, specify: \_\_\_\_\_

**In what setting was the patient most likely exposed?**

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

**Does the patient have any other risk factors for this disease?**.....Y N U  
 Specify: \_\_\_\_\_

**TREATMENT**

**Did patient take an antibiotic as treatment for this illness?**.....Y N U  
 If yes, specify antibiotic name: \_\_\_\_\_  
 Treatment location:  
 Outpatient  
 Inpatient  
 Unknown  
 Date antibiotic began (mm/dd/yyyy): \_\_\_\_\_  
 Date antibiotic ended (mm/dd/yyyy): \_\_\_\_\_  
 Number of days taken: \_\_\_\_\_ Unknown

**Has the patient ever received immune globulin?**.....Y N U  
 When was the last dose received?  
 (mm/dd/yyyy): \_\_\_\_\_

**Did the patient receive medical care for this illness?...**  
Y N U  
 Specify level(s) of care (check all that apply):  
 Outpatient  
 Emergency department  
 Inpatient  
 ICU  
 Other  
 Unknown

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

### HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

**During the 35 days prior to onset of symptoms until 6 weeks after onset of illness, did the patient have any of the following health care exposures?**

**Emergency Dept.** (not hospitalized)...  Y  N  U  
 Visit/admit date (mm/dd/yyyy): \_\_\_\_\_  
 Facility name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Country \_\_\_\_\_  
 Was facility notified regarding ill patient?  
 Yes  No  Unknown  Not applicable  
 Name of person notified \_\_\_\_\_  
 Date notified (mm/dd/yyyy): \_\_\_\_\_

**Hospital** .....  Y  N  U  
 Visit/admit date (mm/dd/yyyy): \_\_\_\_\_  
 Facility name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Country \_\_\_\_\_  
 Has patient been discharged? .....  Y  N  U  
 Discharge date (mm/dd/yyyy): \_\_\_\_\_  
 Was facility notified regarding ill patient?  
 Yes  No  Unknown  Not applicable  
 Name of person notified \_\_\_\_\_  
 Date notified (mm/dd/yyyy): \_\_\_\_\_

**LTC facility—resident** .....  Y  N  U  
 Visit/admit date (mm/dd/yyyy): \_\_\_\_\_  
 Facility name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Country \_\_\_\_\_  
 Has patient been discharged? .....  Y  N  U  
 Discharge date (mm/dd/yyyy): \_\_\_\_\_  
 Was facility notified regarding ill patient?  
 Yes  No  Unknown  Not applicable  
 Name of person notified \_\_\_\_\_  
 Date notified (mm/dd/yyyy): \_\_\_\_\_

**Outpatient facility—patient** .....  Y  N  U  
 Visit date (mm/dd/yyyy): \_\_\_\_\_  
 Facility name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Country \_\_\_\_\_  
 Was facility notified regarding ill patient?  
 Yes  No  Unknown  Not applicable  
 Name of person notified \_\_\_\_\_  
 Date notified (mm/dd/yyyy): \_\_\_\_\_

**Visitor to health care setting** .....  Y  N  U  
 Visit date (mm/dd/yyyy): \_\_\_\_\_  
 Until date (mm/dd/yyyy): \_\_\_\_\_  
 Frequency:  
 Once  
 Multiple times within this time period  
 Daily  
 Facility name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Country \_\_\_\_\_  
 Was facility notified regarding ill patient?  
 Yes  No  Unknown  Not applicable  
 Name of person notified \_\_\_\_\_  
 Date notified (mm/dd/yyyy): \_\_\_\_\_

Name: \_\_\_\_\_  
 Notes: \_\_\_\_\_

**Worked or volunteered in health care or clinical setting** .....  Y  N  U  
 Facility name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Country \_\_\_\_\_  
 Occupation:  
 Physician  
 Physician's assistant or nurse practitioner  
 Nurse  
 Laboratory  
 Other  
 Unknown  
 Specify work setting or volunteer duties: \_\_\_\_\_

Was facility notified regarding ill patient?  
 Yes  No  Unknown  N/A  
 Name of person notified \_\_\_\_\_  
 Date notified (mm/dd/yyyy): \_\_\_\_\_  
**Other, specify** \_\_\_\_\_

**Has the patient ever worked in a healthcare or clinical laboratory setting?** .....  Y  N  U  
 If yes, specify and give details: \_\_\_\_\_

**During the timeframe displayed above, has the patient had other blood and body fluid exposures?** .....  No  Other  Unknown  
**Human saliva/oral secretions exposure** (e.g. shared water bottle, cigarettes, eating utensils, kissing)? .....  Y  N  U  
 Specify and give details: \_\_\_\_\_

### CASE INTERVIEWS/INVESTIGATIONS

**Was the patient interviewed?** .....  Y  N  U  
 Date of interview (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Were interviews conducted with others?** .....  Y  N  U  
 Who was interviewed? \_\_\_\_\_

**Were health care providers consulted?** .....  Y  N  U  
 Who was consulted? \_\_\_\_\_

**Medical records reviewed (including telephone review with provider/office staff)?** .....  Y  N  U  
**Specify reason if medical records were not reviewed:** \_\_\_\_\_

**Notes on medical record verification:** \_\_\_\_\_

### GEOGRAPHICAL SITE OF EXPOSURE

**In what geographic location was the patient MOST LIKELY exposed?**  
 Specify location:  
 In NC  
 City \_\_\_\_\_  
 County \_\_\_\_\_  
 Outside NC, but within US  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 County \_\_\_\_\_

Outside US  
 City \_\_\_\_\_  
 Country \_\_\_\_\_  
 Unknown

**Notes:** \_\_\_\_\_

### TRAVEL

**Was patient pregnant while traveling?**  Y  N  U  
 If yes, was travel during the first trimester of pregnancy?  
 .....  Y  N  U

**Does patient know anyone else with similar symptom(s) who had the same or similar travel history?** .....  Y  N  U

# **Poliomyelitis, Paralytic**

## **1997 Case Definition**

### **Clinical case definition**

Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss

### **Case classification**

*Probable:* a case that meets the clinical case definition

*Confirmed:* a case that meets the clinical case definition and in which the patient has a neurologic deficit 60 days after onset of initial symptoms, has died, or has unknown follow-up status