



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

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

Medical provider completing clinical component of surveillance form: Name/Title: _____ Telephone: (____) _____ - _____ Fax: (____) _____ - _____ Date completed ____/____/____	LHD CD nurse/designee completing form for submission to DPH: Name/Title (print): _____ Telephone: (____) _____ - _____ Date completed ____/____/____ LHD CD nurse/designee signature _____
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LOCAL HEALTH DEPARTMENT USE ONLY

Check one:
 Case definition is met.
(Complete Part 1 and Part 2 and submit to state)
 Case definition is not met.
(Complete Part 2 only and submit to state)

GENERAL DIAGNOSTIC INFORMATION

Is/was patient symptomatic?..... Y N U
 Date of illness onset (mm/dd/yyyy): ____/____/____
 Date of diagnosis (mm/dd/yyyy): ____/____/____
 Patient's health care provider for this illness

 Name of provider's practice or facility

 Telephone number for health care provider
 (____) _____ - _____

CLINICAL FINDINGS

Fever..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> Yes, subjective <input type="checkbox"/> No <input type="checkbox"/> Yes, measured <input type="checkbox"/> Unknown Highest measured temperature _____ Fever onset date (mm/dd/yyyy): _____ Was the fever recurring, remittent, or intermittent?..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Fatigue or malaise or weakness..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Did the patient have any immunity studies performed?..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Please specify: _____ Headache..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Stiff neck..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Meningitis..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Cranial nerve or bulbar weakness or paralysis..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Please specify: _____ Difficulty swallowing (dysphagia)..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Muscle paralysis..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Acute flaccid paralysis..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Onset date (mm/dd/yyyy): _____ <input type="checkbox"/> Asymmetric <input type="checkbox"/> Symmetric Pseudoparalysis..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Respiratory paralysis..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Onset date (mm/dd/yyyy): _____	Paralysis..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Site: <input type="checkbox"/> Spinal <input type="checkbox"/> Bulbar <input type="checkbox"/> Spino-bulbar Specific site _____ 60-day residual: <input type="checkbox"/> None <input type="checkbox"/> Minor (any minor involvement) <input type="checkbox"/> Significant (≤ 2 extremities, major involvement) <input type="checkbox"/> Severe (≥ 3 extremities and respiratory involvement) <input type="checkbox"/> Death <input type="checkbox"/> Unknown Muscle aches / pains (myalgias)..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U EMG performed..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Date performed (mm/dd/yyyy): _____ Result: _____ Nerve conduction study performed..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Date performed Result Nausea..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Vomiting..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Other symptoms, signs, clinical findings, or complications consistent with this illness?..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U If yes, specify: _____
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PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ... Y N U
 Specify _____
 HIV/AIDS..... Y N U
**Immunosuppressive conditions
 (not including HIV/AIDS).....** Y N U
Any immunosuppressive conditions..... 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?

REASON FOR TESTING

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

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

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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: _____

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

HOSPITALIZATION INFORMATION

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): ____/____/____

ICU admission? Y N U

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:

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Status at time of report:

Fully recovered

Survived but experiencing sequelae (residual deficit from illness) at time of report

Died? Y N U

If yes:

Died from this illness? Y N U

If yes, location of death:

Home

Emergency Department

Hospital ICU

Hospital inpatient

En route to hospital

Long-term care facility

Other, specify: _____

Unknown

Patient died in North Carolina? Y N U

County of death: _____

Died outside NC? Y N U

Specify where: _____

Autopsy performed? Y N U

Facility where autopsy was performed: _____

Patient autopsied in NC? Y N U

County of autopsy: _____

Autopsied outside NC, specify where: _____

Source of death information (select all that apply):

Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.

Death certificate

Autopsy report final conclusions

Hospital/physician discharge summary

Other: _____

Cause of death: _____

Death date (mm/dd/yyyy): _____

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TRAVEL/IMMIGRATION

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 Airline / Ship crew

Organized tour Missionary or dependent

Business related, specify _____

Military related Refugee / Immigrant

Visit to family / friends Student / Teacher

Peace corps 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: _____

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

Name: _____

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: _____

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, has the patient attended 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"/> Prison/Jail/Detention Center	<input type="checkbox"/> Unknown

Does the patient have any other risk for this disease? Y N U

Specify: _____

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

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 occupation: _____

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

OTHER EXPOSURE INFORMATION

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

If yes, specify:

