Polio

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Investigation Information

*indicates required fields

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	**First Name***	**Middle Initial**

Street Address

City	**County**	**State**	**Zip**
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**	**Report Date** mm/dd/yyyy

Parent / Guardian Information

Last Name	**First Name**	**Middle Initial**	**Relationship to Patient**

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	**County**	**State**	**Zip**
		West Virginia	

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	**Age**	**Age Units**
		○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Patient Demographic Information cont.

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native*
☐ *Asian*
☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White*
☐ *Unknown*
☐ *Failure to report race/missing race*
☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy	**Date of diagnosis** mm/dd/yyyy

Was patient hospitalized for this disease? ○ *Yes* ○ *No* ○ *Unknown*	**Name of Hospital**	**Date of Admission** mm/dd/yyyy

Patient outcome from this disease: ○ *Died* ○ *Survived* ○ *Unknown*	**Date of Death** mm/dd/yyyy

Autopsy Performed?

○ *Yes* ○ *No* ○ *Unknown*

Onset of Paralysis mm/dd/yyyy	**Date of 60-day follow up** mm/dd/yyyy	**Site of Paralysis** ○ *Spinal* ○ *Bulbar* ○ *Spino-bulbar*

60-day residual

○ *None* ○ *Minor (any minor involvement)* ○ *Significant (< or = 3 extremities and respiratory involvement)* ○ *Death* ○ *Unknown*

Laboratory Information

Serum specimens submitted

Serum 1

Lab Name	**Test (Neut, CF)**	**Collection Date** mm/dd/yyyy	**Result Date** mm/dd/yyyy

P1	**P2**	**P3**

Serum 2

Lab Name	**Test (Neut, CF)**	**Collection Date** mm/dd/yyyy	**Result Date** mm/dd/yyyy

P1	**P2**	**P3**

Specimens submitted for isolation

No.	Lab Name	Specimen Type	Collection Date	Result Date	Result
			mm/dd/yyyy	mm/dd/yyyy	
1.					
2.					

Laboratory Information cont.

CDC Laboratory

Serum specimens sent to CDC?

○ *Yes* ○ *No*

Date Received
mm/dd/yyyy

Serum	Test	Collection Date	P1	P2	P3
		mm/dd/yyyy			
1.					
2.					

Specimens for polio virus isolation sent to CDC

○ *Yes* ○ *No*

Date Received
mm/dd/yyyy

No.	Specimen Type	Date Collected	Result Date (viral type)
		mm/dd/yyyy	mm/dd/yyyy
1.			
2.			

Strain characterization results

○ *Genomic sequencing* ○ *Polymerase chain reaction*

Special Investigations

EMG conducted

○ *Yes* ○ *No* ○ *Unknown*

If Yes, Results

Date of Result
mm/dd/yyyy

Nerve Conduction

○ *Yes* ○ *No* ○ *Unknown*

If Yes, Results

Date of Result
mm/dd/yyyy

Immune deficiency diagnosed prior to OPV exposure

○ *Yes* ○ *No* ○ *Unknown*

If Yes, Diagnosis

Immune studies performed

HIV Status:

○ *Positive* ○ *Negative* ○ *Unknown*

Laboratory Name

Phone
###-###-####

Ext.

Fax Number
###-###-####

Address

State:
West Virginia

Zip:

Reporting Source

Last Name

First Name

Phone
###-###-####

Ext.

Fax
###-###-####

Facility

Address

City

State
West Virginia

Zip

Reporting Source cont.

E-mail

Provider with Further Patient Information

Last Name	**First Name**

Phone ###-###-####	**Ext.**	**Fax** ###-###-####

Address

City	**State**	**Zip**
	West Virginia	

Public Health Investigation

Name of Person Interviewed	**Relationship to Patient**	**Date reported to public health** mm/dd/yyyy

Investigator	**Date public health investigation began** mm/dd/yyyy	**Health Department**	**Phone** ###-###-####

Ext.	

Investigation ID	**Part of an Outbreak?**	**Outbreak Name**	**Lost to follow-up?**
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

Vaccine History

Received TOPV prior to onset of symptoms?	**If Yes, date:** mm/dd/yyyy	**Lot #**
○ *Yes* ○ *No* ○ *Unknown*		

MOPV

MOPV - Total doses ever received

No.	**Date**	**Lot #**
	mm/dd/yyyy	
1.		
2.		
3.		
4.		
5.		
6.		

Vaccine History cont.

TOPV

TOPV - Total doses ever received

No.	Date	Lot #
	mm/dd/yyyy	
1.		
2.		
3.		
4.		
5.		
6.		

IPV

IPV - Total doses ever received

No.	Date	Lot #
	mm/dd/yyyy	
1.		
2.		
3.		
4.		
5.		
6.		

If Not Vaccinated, What Was the Reason?

- ○ *Religious exemption*
- ○ *Medical Contraindication*
- ○ *Philosophical Exemption*
- ○ *Lab evidence of previous disease*
- ○ *MD diagnosis of previous disease*
- ○ *Under age for vaccination*
- ○ *Parental refusal*
- ○ *Other (specify):*_____
- ○ *Unknown*

Total number of simultaneous injections at the time of polio vaccination

Injection(s) 30 days prior to illness onset:

1st Injection

Date of first injection
mm/dd/yyyy

Site of first injection

○ *Left Deltoid* ○ *Right Deltoid* ○ *Left Thigh* ○ *Right Thigh* ○ *Left Gluteal* ○ *Right Gluteal*

1st Injected Substance

○ *Vaccine* ○ *Antibiotic* ○ *Other*_____

2nd Injection

Date of second injection
mm/dd/yyyy

Site of second injection

○ *Left Deltoid* ○ *Right Deltoid* ○ *Left Thigh* ○ *Right Thigh* ○ *Left Gluteal* ○ *Right Gluteal*

2nd Injected Substance

○ *Vaccine* ○ *Antibiotic* ○ *Other*_____

3rd Injection

Date of third injection
mm/dd/yyyy

Site of third injection

○ *Left Deltoid* ○ *Right Deltoid* ○ *Left Thigh* ○ *Right Thigh* ○ *Left Gluteal* ○ *Right Gluteal*

3rd Injected Substance

○ *Vaccine* ○ *Antibiotic* ○ *Other*_____

Vaccine History cont.

4th Injection

Date of fourth injection mm/dd/yyyy	**Site of fourth injection** ○ *Left Deltoid* ○ *Right Deltoid* ○ *Left Thigh* ○ *Right Thigh* ○ *Left Gluteal* ○ *Right Gluteal*

4th Injected Substance
○ *Vaccine* ○ *Antibiotic* ○ *Other*_____

Case/HH Travel

Case/HH member travel to endemic/epidemic area ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, Who:**	**Where:**	**When:**

Case/HH Exposure

Case/HH exposure to person(s) from or returning from endemic areas ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, Who:**
Where:	**When:**

Contact with known case

Case/HH contact with known case ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, Who:**	**Where:**	**When:**

Contact with OPV recipient

Case had contact with OPV recipient ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, Household contact**	**Date** mm/dd/yyyy	**Age**

Relation	**Non-household contact**	**Date** mm/dd/yyyy	**Age**	**Relation**

Date contact received OPV mm/dd/yyyy	**Dose**	**Lot #**

Case had contact with IPV recipient
○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date contact received:

1st IPV mm/dd/yyyy	**2nd IPV** mm/dd/yyyy	**3rd IPV** mm/dd/yyyy	**4th IPV** mm/dd/yyyy	**Lot # of most recent IPV**

Public health action taken