# Acute Flaccid Paralysis (AFP) Notification Form

HPA-SUR-U00047-F-2017-3

**Centre for Community Health and Disease Control**

Male' Maldives

| **HPA USE** | Case No: MAV/ | Year: |
|---|---|---|

## 1. Notification Information

| | | |
|---|---|---|
| Notifying health facility: (Name/ Island/ Atoll/ Region) | | |
| Notified by (person): | Title: | |
| Received by (person): | Title: | |
| Date case notified to HPA: | Date received by HPA: | |

## 2. Case Identification

| | | | |
|---|---|---|---|
| **Patient's Name:** | Sex: | Date of Birth: | ID/PP No: |
| **Legal guardian's name:** | | Atoll & Island: | Contact No: |
| Temporary Address: | | Atoll & Island: | |
| Permanent Address: | | Atoll & Island: | Nationality: |

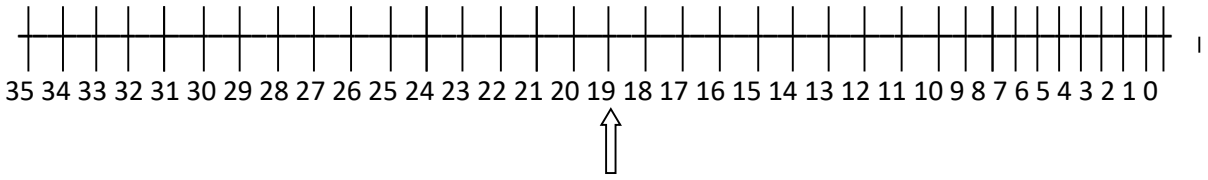
## 3. Immunization History (To be confirmed from immunization card)

| | | | | |
|---|---|---|---|---|
| **OPV Doses received through routine EPI:** | ☐Yes | ☐No | Total Routine OPV Doses: | |
| **OPV Doses received through routine SIA:** | ☐Yes | ☐No | Total OPV Doses through SIA: | |
| **Date of last dose of OPV:** To be completed by HPA | | | | |

## 4. Travel History

Travel of child within 35 days prior to onset of paralysis *(Indicate dates and place of travel with arrows on date line)*

**Write travel dates** ⇩ **Day of onset** ⇩




**Write here places visited corresponding to the travel dates**

| Requires cross notification? Yes☐/ No☐/ Not applicable☐ | | |
|---|---|---|
| If yes, date of cross notification: | Place notified by | Place of residence |

**5. Hospitalization:**

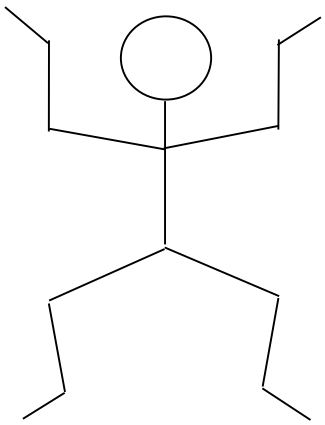
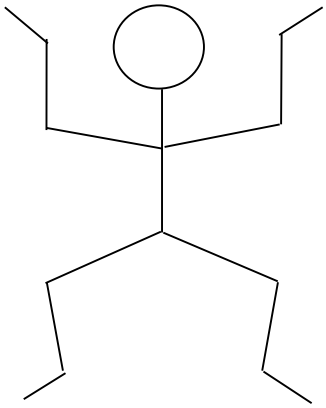
| Date of hospitalization (initial): | Hospital Record No: |
|---|---|
| Name of Hospital: | |
| Date of hospitalization (referral): | Hospital Record No: |
| Name of Hospital: | |

**6. Clinical History:**

| Onset of signs and symptoms: | Onset of paralysis: |
|---|---|

✓ *Tick where appropriate*

| **Signs and symptoms** | Yes | No | Unknown | Paralysis/ Paresis | Yes | No | Unknown |
|---|---|---|---|---|---|---|---|
| **Fever** | | | | **Sudden** | | | |
| **Nausea/vomiting** | | | | **Flaccid** | | | |
| **Diarrhea** | | | | **Paralysis progressed more than three days of onset** | | | |
| **Constipation** | | | | **Ascending** | | | |
| **Sore throat** | | | | **Descending** | | | |
| **Muscular pain** | | | | **Asymmetric** | | | |
| **Headache** | | | | | | | |
| **Stiff neck** | | | | | | | |
| **Sensation loss** | | | | | | | |
| **Respiratory involvement** | | | | | | | |
| **Bulbar involvement** | | | | | | | |
| **Gait** | | | | | | | |
| **Bladder/Bowel** | | | | | | | |
| **Injections 30 days-** | | | | **If yes- side and site of injection** | | | |

| **7. Clinical examination:** | | | | |
|---|---|---|---|---|
| **Clinical examination** | Initial case investigation<br><br>Date:<br><br>Examined by : | | 60-day follow-up<br><br>Date:<br><br>Examined by: | |
| **Tone( normal/↑/↓** | UL :Right<br>left | LL :Right<br>left | UL :Right<br>left | LL :Right<br>left |
| **Power ( Grade 0 to 5)**<br><br>**0-No contraction**<br>**1-Flicker of contraction**<br>**2- Active movement with gravity eliminated**<br>**3-Active movement against gravity but no resistance**<br>**4-Active movement against resistance**<br>**5-Normal** |  | |  | |
| **Reflexes:** | **N/↑/↓/absent/uncooperative child** | **N/↑/↓/absent/uncooperative child** | **N/↑/↓/absent/uncooperative child** | **N/↑/↓/absent/uncooperative child** |
| **Biceps** | Right | Left | Right | Left |
| **Triceps** | Right | Left | Right | Left |
| **Supinator** | Right | Left | Right | Left |
| **Knee Jerk** | Right | Left | Right | Left |
| **Ankle Jerk** | Right | Left | Right | Left |
| **Plantar** | Right: flexor/ extensor/uncooperative child | Left: flexor/ extensor/uncooperative child | Right: flexor/ extensor/uncooperative child | Left: flexor/ extensor/uncooperative child |
| **Circumference:** | Right | Left | Right | Left |
| **Mid-arm** | Right | Left | Right | Left |
| **Fore-arm** | Right | Left | Right | Left |
| **Mid-thigh** | Right | Left | Right | Left |
| **Mid-calf** | Right | Left | Right | Left |
| **Cranial nerves affected** | Right | Left | Right | Left |
| **Additional comments** | | | | |

## 8. Stool specimen

| | Date collected | Date sent | Date of result | Laboratory result (P1, P2, P3, Wild, Vax, NPEV, Negative) |
|---|---|---|---|---|
| **Stool sample 1** | | | | |
| **Stool sample 2** | | | | |

**If stool not collected in 14 days why?*

☐ Late investigation ☐ Delay in stool collection ☐ Late notification ☐ *Constipation* ☐ Lost

☐ Others _____

## 9. Final Classification:

☐Confirmed Polio ☐Compatible ☐Discarded:

If compatible, why?

If discarded, final diagnosis:

☐Gullain-Barre Syndrome ☐Meningitis

☐Transverse Myelitis ☐Non-polio enterovirus

☐Traumatic Neuritis ☐Tumors

☐Viral Myositis, Encephalitis ☐Hypokalemic paralysis or weakness

☐Other (specify):

## 10. Case closed by: (Expert Committee)

| | |
|---|---|
| **Name:** | **Name:** |
| **Designation:** | **Designation:** |
| **Sign:** | **Sign:** |
| **Date:** | **Date:** |

**For further information or inquiries, please contact:**
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Forms and case definition booklet are available on **http://www.health.gov.mv**