

# 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Closed  Open  Regional Review  State Review  Superseded  Unassigned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**

West Virginia

**Zip**

**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**

West Virginia

**Zip**

**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

<b>Date of onset of symptoms</b> mm/dd/yyyy	<b>Date of diagnosis</b> mm/dd/yyyy
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<b>Was patient hospitalized for this disease?</b> <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	<b>Name of Hospital</b>	<b>Date of Admission</b> mm/dd/yyyy
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<b>Patient outcome from this disease:</b> <input type="radio"/> <i>Died</i> <input type="radio"/> <i>Survived</i> <input type="radio"/> <i>Unknown</i>	<b>Date of Death</b> mm/dd/yyyy
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**Autopsy Performed?**  
 *Yes*    *No*    *Unknown*

<b>Onset of Paralysis</b> mm/dd/yyyy	<b>Date of 60-day follow up</b> mm/dd/yyyy	<b>Site of Paralysis</b> <input type="radio"/> <i>Spinal</i> <input type="radio"/> <i>Bulbar</i> <input type="radio"/> <i>Spino-bulbar</i>
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**60-day residual**  
 *None*    *Minor (any minor involvement)*    *Significant (< or = 3 extremities and respiratory involvement)*    *Death*    *Unknown*

## Laboratory Information

Serum specimens submitted

Serum 1			
<b>Lab Name</b>	<b>Test (Neut, CF)</b>	<b>Collection Date</b> mm/dd/yyyy	<b>Result Date</b> mm/dd/yyyy
<b>P1</b>	<b>P2</b>	<b>P3</b>	

Serum 2			
<b>Lab Name</b>	<b>Test (Neut, CF)</b>	<b>Collection Date</b> mm/dd/yyyy	<b>Result Date</b> mm/dd/yyyy
<b>P1</b>	<b>P2</b>	<b>P3</b>	

Specimens submitted for isolation

No.	Lab Name	Specimen Type	Collection Date mm/dd/yyyy	Result Date mm/dd/yyyy	Result
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 ###-###-####
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Address

State: West Virginia	Zip:
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## Reporting Source

Last Name	First Name
Phone ###-###-####	Ext.
	Fax ###-###-####

Facility

Address

City	State West Virginia	Zip
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## Reporting Source cont.

E-mail

## Provider with Further Patient Information

Last Name

First Name

Phone

###-###-####

Ext.

Fax

###-###-####

Address

City

State

West Virginia

Zip

## 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?

 Yes  No  Unknown

Outbreak Name

Lost to follow-up?

 Yes  No

## Vaccine History

Received TOPV prior to onset of symptoms?

 Yes  No  Unknown

If Yes, date:

mm/dd/yyyy

Lot #

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.

<b>4th Injection</b>				
<b>Date of fourth injection</b> mm/dd/yyyy		<b>Site of fourth injection</b> <input type="radio"/> Left Deltoid <input type="radio"/> Right Deltoid <input type="radio"/> Left Thigh <input type="radio"/> Right Thigh <input type="radio"/> Left Gluteal <input type="radio"/> Right Gluteal		
<b>4th Injected Substance</b> <input type="radio"/> Vaccine <input type="radio"/> Antibiotic <input type="radio"/> Other _____				
<b>Case/HH Travel</b>				
<b>Case/HH member travel to endemic/epidemic area</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		<b>If Yes, Who:</b>	<b>Where:</b>	<b>When:</b>
<b>Case/HH Exposure</b>				
<b>Case/HH exposure to person(s) from or returning from endemic areas</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			<b>If Yes, Who:</b>	
<b>Where:</b>			<b>When:</b>	
<b>Contact with known case</b>				
<b>Case/HH contact with known case</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		<b>If Yes, Who:</b>	<b>Where:</b>	<b>When:</b>
<b>Contact with OPV recipient</b>				
<b>Case had contact with OPV recipient</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		<b>If Yes, Household contact</b>	<b>Date</b> mm/dd/yyyy	<b>Age</b>
<b>Relation</b>	<b>Non-household contact</b>	<b>Date</b> mm/dd/yyyy	<b>Age</b>	<b>Relation</b>
<b>Date contact received OPV</b> mm/dd/yyyy		<b>Dose</b>	<b>Lot #</b>	
<b>Case had contact with IPV recipient</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				
<b>If Yes, Date contact received:</b>				
<b>1st IPV</b> mm/dd/yyyy	<b>2nd IPV</b> mm/dd/yyyy	<b>3rd IPV</b> mm/dd/yyyy	<b>4th IPV</b> mm/dd/yyyy	<b>Lot # of most recent IPV</b>
<b>Public health action taken</b>				