Acute Flaccid Paralysis (AFP) Case Investigation Tool

Public Health Ontario | Santé publique Ontario

iPHIS Case ID:

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This tool is intended to support public health units with investigating reports of acute flaccid paralysis (AFP). It outlines key data collection elements and iPHIS data entry requirements to support AFP surveillance. Use of this tool is optional and is not required to be submitted to Public Health Ontario.

Surveillance is conducted to identify cases of AFP and investigate these cases in order to **rule out poliomyelitis (polio)**, which is essential for documenting global polio elimination.

Refer to Appendix 1 for the AFP case definition and information on case and contact management.

1 - CLIENT INFORMATION

Last name: | Parent / Guardian (if applicable) Last name:

First name: | First name:

Date of birth (yyyy-mm-dd): | Ontario Health Card Number:

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other ☐ Unknown

Contact Information:

Address: | City / Town:

Postal Code: | Province: | ☐ No Fixed Address:

Primary phone #: | ☐ Home ☐ Mobile ☐ Work ☐ Other

Alternate phone #: | ☐ Home ☐ Mobile ☐ Work ☐ Other

Email:

Client Language / Proxy Info:

Preferred language: ☐ English ☐ French ☐ Other: | If Other, specify:

Translation required? ☐ Yes ☐ No | Proxy respondent (if applicable)? ☐ Yes ☐ No

Proxy Name:

Relationship to client: | Proxy Phone #:

2 - REPORTING HEALTHCARE PROVIDER INFORMATION

Reported to PHU date (yyyy-mm-dd):

Name: Tel.

Clinic / Hospital name:

Role: ☐ Attending Physician ☐ Family Physician ☐ Specialist ☐ Walk-in Physician ☐ Nurse Practitioner

☐ Unknown ☐ Other Specify:

3 - CASE DETAILS

Initial Case Classification:

☐ Person Under Investigation ☐ Confirmed ☐ Does Not Meet Initial Case Classification date (yyyy-mm-dd):

Final Case Classification:

☐ Confirmed ☐ Does Not Meet Final Case Classification date (yyyy-mm-dd):

Diagnosing Health Unit:

Responsible Health Unit:

4 - CLINICAL INFORMATION / SYMPTOMS

Paralysis / Weakness:

Onset Date (yyyy-mm-dd):

Fever present at onset of paralysis / weakness: ☐ Yes ☐ No ☐ Unknown If Yes, onset date (yyyy-mm-dd):

Details (e.g., affected area(s), progression, severity etc.):

Date paralysis/weakness reached full extent or maximal weakness (yyyy-mm-dd):

Other symptoms:

5 - LABORATORY INFORMATION / INVESTIGATIONS

In all cases of acute flaccid paralysis, **two stool specimens** should be collected at least 48 hours apart, ideally **within 2 weeks** of the onset of paralysis and examined for poliovirus (samples can be collected up to 6 weeks after onset if it is not possible to collect earlier). Further guidance on laboratory testing for poliovirus is available here.

Note: Campylobacter testing on the stool samples can be requested if Guillain–Barré syndrome (GBS) is suspected.

Laboratory testing status: ☐ Completed ☐ Pending ☐ Not done

Specimen 1:	**Specimen 2:**	**Specimen 3:**	**Specimen 4:**
Type and site: Stool	Type and site:	Type and site:	Type and site:
Test: Other (specify)	Test:	Test:	Test:
Result:	Result:	Result:	Result:
Results details:	Results details:	Results details:	Results details:
Other, specify:	Other, specify:	Other, specify:	Other, specify:
Date collected: / Date of Result:	Date collected: / Date of Result:	Date collected: / Date of Result:	Date collected: / Date of Result:

If **poliovirus** detected: Type(s) (if available): P1 ☐ P2 ☐ P3 ☐ Strain (if available): Wild ☐ Vaccine ☐

If **Campylobacter** detected: Species (if available):

Were there symptoms of a current or recent (≤ 6 weeks before onset) infection? ☐ Yes ☐ No ☐ Unknown

If yes, describe the type of infection (Respiratory tract, Gastrointestinal, Other (describe):

Was there a positive laboratory test confirming an infection? (e.g., microbiological or serological) ☐ Yes ☐ No ☐ Unknown

If yes, specify the organism or infection identified:

Neurological investigations:

Status: ☐ Completed ☐ Pending ☐ Not done ☐ Unknown

Type: ☐ Electromyography ☐ Nerve conduction studies ☐ MRI ☐ CT

Results: ☐ Normal ☐ Abnormal (describe) ☐ Unknown

If abnormal, please describe:

6 - RISK FACTORS

Medical Risk Factors:

Immunocompromised: ☐ Yes ☐ No ☐ Unknown If Yes, briefly describe:

Abnormal neurological history : ☐ Yes ☐ No ☐ Unknown If Yes, briefly describe:

Other relevant medical history:

Behavioural Risk Factors:

Is the client a member of a group / community that is known to be unvaccinated or under-vaccinated? ☐ Yes ☐ No ☐ Unknown

Has the client travelled to, or resided in, another country within 6 weeks (42 days) prior to the onset of this illness, particularly to polio endemic or infected countries or an area where oral polio vaccine (OPV) is used? ☐ Yes ☐ No ☐ Unknown

If yes, specify location(s) and dates:

Has any **household member** or other **close contact** travelled to, or resided in, another country within 6 weeks prior to the client's illness? ☐ Yes ☐ No ☐ Unknown

If yes, specify location(s) and dates:

In the past 6 weeks, has the client had any contact with a person being investigated for paralysis or polio? ☐ Yes ☐ No ☐ Unknown

If yes, describe:

Other behavioural risk factors (specify):

7 - IMMUNIZATION HISTORY

Has client received oral polio vaccine (OPV) within 42 days prior to onset of the current illness? Note: OPV is still being used in countries outside of Canada. ☐ Yes ☐ No ☐ Unknown

If Yes, date (yyyy-mm-dd):

Has client received any other immunization(s), including inactivated poliomyelitis vaccine (IPV), within 42 days prior to onset of the current illness? ☐ Yes ☐ No ☐ Unknown

If yes, complete fields on next page (page 5)

IMMUNIZATION HISTORY CONTINUED

Entry 1:

Date: Exact Date **Or** Estimated Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 2:

Date: Exact Date **Or** Estimated Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 3:

Date: Exact Date **Or** Estimated Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 4:

Date: Exact Date **Or** Estimated Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 5:

Date: Exact Date **Or** Estimated Site: Dose Number:

Agent: Lot Number: Source of info:

Has any **household member** or other **close contact** received oral polio vaccine (OPV) within 60 days prior to onset of this client's illness? Yes No Unknown

If yes, indicate below the relationship of each vaccinated individual to this client, and the date of vaccination:

	Relationship to client:	**Date of vaccination (yyyy-mm-dd):**		
1.			Exact	Estimated
2.			Exact	Estimated
3.			Exact	Estimated
4.			Exact	Estimated
5.			Exact	Estimated

8 - INTERVENTIONS

Hospitalization: Yes (If Yes, complete the following fields) No

Admission date: Hospital Name:

Discharge date: Admission details:

ICU admission: ☐ Yes (If Yes, complete the following fields) ☐ No

Admission date: Hospital Name:

Discharge date: Admission details:

9 - COMPLICATIONS AND OUTCOME

Complications: ☐ Loss of full strength ☐ Other residual neurologic deficit ☐ Relapse of GBS
☐ Mechanical ventilation ☐ Persistent pain ☐ None

Final neurological diagnosis: ☐ Guillain-Barré syndrome (GBS) ☐ GBS (Miller-Fisher Variant) ☐ Acute poliomyelitis
☐ Transverse myelitis ☐ Acute disseminated encephalomyelitis (ADEM) ☐ Vaccine-associated paralytic poliomyelitis
☐ Other Specify:

Indicate the level of certainty associated with the final diagnosis (as entered on CPS questionnaire, if applicable): ☐ Probable ☐ Definite ☐ N/A

Outcome: ☐ Residual effects ☐ Recovered ☐ Not yet recovered ☐ Fatal ☐ Unknown

Outcome date: Note: Outcome should be collected 60 days following onset to confirm whether residual effects are still present.

10 - PROGRESS / CLINICAL NOTES

Enter progress or clinical notes:

11 - CASE INVESTIGATORS

Case manager #1: Signature: Date: Time:

Case manager #2: Signature: Date: Time:

Ontario