CONFIDENTIAL

Iowa Department of Public Health

Poliomyelitis

Agency:

Investigator:

Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other ____
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: **Poliovirus** Type:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: **Poliovirus** Type:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: **Poliovirus** Type:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: ____________ Job title: ____________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________
Date worked from: __/__/__ Address: ____________
Date worked to: __/__/__ Zip code: ____________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ________ State: ____ County: ________
Date removed: __/__/__ Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: ____________ Job title: ____________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________
Date worked from: __/__/__ Address: ____________
Date worked to: __/__/__ Zip code: ____________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ________ State: ____ County: ________
Date removed: __/__/__ Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ____________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): ________
Admission date: __/__/__ Discharge date: __/__/__ Days hospitalized: ________
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

Hospital: ____________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): ________
Admission date: __/__/__ Discharge date: __/__/__ Days hospitalized: ________
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms

Paralysis: ☐ Yes ☐ No ☐ Unk Onset date: __/__/__ Paralysis sites: ____________

Symptom				Symptom			
Fever	☐ Yes	☐ No	☐ Unk	Paralysis	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk	Stiff neck	☐ Yes	☐ No	☐ Unk
Muscle pain	☐ Yes	☐ No	☐ Unk	Trouble swallowing	☐ Yes	☐ No	☐ Unk
Nausea	☐ Yes	☐ No	☐ Unk	Vomiting	☐ Yes	☐ No	☐ Unk

Tensilon test performed: ☐ Yes ☐ No ☐ Unk
Date of test: __/__/__
Results: ☐ Positive ☐ Equivocal ☐ Negative ☐ Unknown

EMG performed: ☐ Yes ☐ No ☐ Unk
Date of test: __/__/__
Results compatible with polio: ☐ Yes ☐ No ☐ Unk

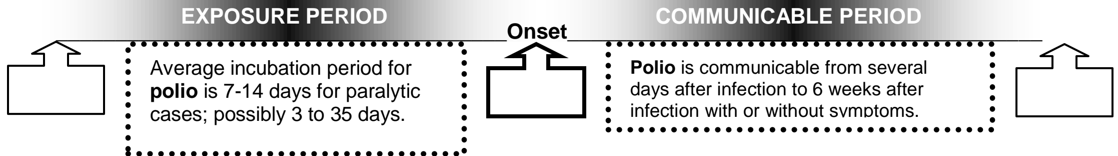
Nerve conduction test performed: ☐ Yes ☐ No ☐ Unk
Date of test: __/__/__
Result:

60-day residual symptoms: ☐ Yes ☐ No ☐ Unk

Symptom				Symptom			
Fever	☐ Yes	☐ No	☐ Unk	Paralysis	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk	Stiff neck	☐ Yes	☐ No	☐ Unk
Muscle pain	☐ Yes	☐ No	☐ Unk	Trouble swallowing	☐ Yes	☐ No	☐ Unk
Nausea	☐ Yes	☐ No	☐ Unk	Vomiting	☐ Yes	☐ No	☐ Unk

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



Average incubation period for **polio** is 7-14 days for paralytic cases; possibly 3 to 35 days.

Polio is communicable from several days after infection to 6 weeks after infection with or without symptoms.

RISK FACTORS/TRAVEL

Vaccinated for Polio? ☐ Yes ☐ No ☐ Unknown

Date vaccinated: ___/___/___	Date vaccinated: ___/___/___	Date vaccinated: ___/___/___
Lot #: ______	Lot #: ______	Lot #: ______
Vaccine type: ______	Vaccine type: ______	Vaccine type: ______
Manufacturer: ______	Manufacturer: ______	Manufacturer: ______

Number of vaccinations: _____

In the 35 days prior to the onset of symptoms did the case:

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: ______ Departure date: ___/___/___ Return date: ___/___/___

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ______ City: ______ Departure date: ___/___/___ Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: ______ Departure date: ___/___/___ Return date: ___/___/___

Exposed to potential cases: ☐ Yes ☐ No ☐ Unk Country outside U.S.: ______ From date: ___/___/___ To date: ___/___/___

Work with a case: ☐ Yes ☐ No ☐ Unk From date: ___/___/___ To date: ___/___/___

Lived with another case: ☐ Yes ☐ No ☐ Unk From date: ___/___/___ To date: ___/___/___

Contact w/t OPV recipient: ☐ Yes ☐ No ☐ Unk Lived w/t recipient: ☐ Yes ☐ No ☐ Unk Age of recipient: ______

Recipient relationship: ☐ Child care contact ☐ Close contact not living in household ☐ Household

CONTACTS

Number of people living in case's household: _____

Close contacts with similar symptoms

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

NOTES: