North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

POLIOMYELITIS, PARALYTIC
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 30

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS

Diagnostic testing for poliomyelitis is complicated and may need to be sent to CDC for testing. Please call the NC state epidemiologist on call at 919-733-3419 immediately if you think you may have a case of polio. Labs results can be entered or attached to the event later--once results are completed.

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):_____
Was the fever recurring, remittent, or intermittent? ☐Y ☐N ☐U
Fatigue or malaise or weakness ☐Y ☐N ☐U
Did the patient have any immunity studies performed? ☐Y ☐N ☐U
Please specify:_____
Headache ☐Y ☐N ☐U
Stiff neck ☐Y ☐N ☐U
Meningitis ☐Y ☐N ☐U
Cranial nerve or bulbar weakness or paralysis ☐Y ☐N ☐U
Please specify:_____
Difficulty swallowing (dysphagia) ☐Y ☐N ☐U
Muscle paralysis ☐Y ☐N ☐U
Acute flaccid paralysis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
☐ Asymmetric
☐ Symmetric
Pseudoparalysis ☐Y ☐N ☐U
Respiratory paralysis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Paralysis ☐Y ☐N ☐U
Site:
☐ Spinal
☐ Bulbar
☐ Spino-bulbar
Specific site_____
Muscle aches / pains (myalgias) ☐Y ☐N ☐U
EMG performed ☐Y ☐N ☐U
Date performed (mm/dd/yyyy):_____
Result:_____

Nerve conduction study performed ☐Y ☐N ☐U
Date performed _____
Result _____
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐Y ☐N ☐U
If yes, specify: _____
Any immunosuppressive conditions? ☐Y ☐N ☐U
Specify _____
_____

PREGNANCY
Is the patient currently pregnant? ☐Y ☐N ☐U
Estimated delivery date (mm/dd/yyyy):_____
Give number of weeks gestation at onset of illness:_____
Has the mother received prenatal care? ☐Y ☐N ☐U
Date of first prenatal visit (mm/dd/yyyy):_____
Number of prenatal visits:_____
Prenatal provider name_____
OB Name _____
Street address_____
City _____
State _____
Zip code _____
Phone (_____) _____
Did patient attend family planning clinic prior to conception? ☐Y ☐N ☐U
Has the patient ever been pregnant? ☐Y ☐N ☐U
Total number of previous pregnancies of the biologic mother:_____
Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State:_____

Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

CLINICAL OUTCOMES
Discharge/Final diagnosis:_____
_____
Survived? ☐Y ☐N ☐U
Date of 60 day follow-up (mm/dd/yyyy):_____
Paralysis? ☐Y ☐N ☐U
Site:
☐ Spinal
☐ Bulbar
☐ Spino-bulbar
☐ Specific site:_____
60-day residual:
☐ None
☐ Minor (any minor involvement)
☐ Significant (≤ 2 extremities, major involvement)
☐ Severe (≥ 3 extremities and □ respiratory involvement)
☐ Unknown
Died? ☐Y ☐N ☐U
If yes:
Died from this illness? ☐Y ☐N ☐U
Death date (mm/dd/yyyy):_____
Autopsy performed? ☐Y ☐N ☐U
Source of death information (select all that apply):
☐ Death certificate
☐ Autopsy report final conclusions
☐ Hospital/physician discharge summary
☐ Other:_____
Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.
Cause of death listed on death certificate: _____
_____

(CONTINUED)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE (CONTINUED)

TRAVEL

The patient is:

- ☐ Resident North Carolina
- ☐ Resident of another state or US territory
- ☐ Foreign visitor
- ☐ Refugee
  - Refugee camp(s)? ☐ Y ☐ N ☐ U
  - Name of camp_____
  - Location of camp_____
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US _____
- ☐ Recent immigrant
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US _____
- ☐ Foreign adoptee
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US _____
- ☐ None of the above

Did patient have a travel history during the 35 days prior to onset of symptoms until 6 weeks after onset of illness? ☐ Y ☐ N ☐ U

Travel dates: From:_____until _____

To city:_____State: _____

To country:_____

Reason(s) for travel:

- ☐ Vacation / tourism
- ☐ Organized tour
- ☐ Business related, specify _____
- ☐ Military related
- ☐ Visit to family / friends
- ☐ Peace corps
- ☐ Airline / Ship crew
- ☐ Missionary or dependent
- ☐ Refugee / Immigrant
- ☐ Student / Teacher
- ☐ Unknown
- ☐ Other_____

Mode(s) of transportation (check all that apply)

- ☐ Airplane
- ☐ Ship / boat / ferry
  - Cruise ship? ☐ Y ☐ N ☐ U
  - Specify cruise line _____
- ☐ Train / subway
- ☐ On foot
- ☐ Bus/taxi/shuttle
- ☐ Automobile / motorcycle
- ☐ Other, specify:_____

Did patient have contact with a person with travel history during the period of interest? ☐ Y ☐ N ☐ U

Contact's name: _____

Travel dates: From:_____until _____

To city: _____

To state:_____

To country:_____

Is contact a:

- ☐ Resident of another state or US territory
- ☐ Foreign visitor
- ☐ Recent immigrant
- ☐ Refugee
- ☐ Foreign adoptee
- ☐ Unknown
- ☐ Other, specify:_____

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

If yes, specify name and relationship to person(s):

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

VACCINE

Has patient / contact ever received vaccine for this disease? ☐ Y ☐ N ☐ U

Date of vaccination #1 ____/____/____ ☐ Unknown

- Dose administered:_____
- Vaccine type:_____
- Manufacturer:_____
- Product/trade name:_____
- Lot number:_____

Date of vaccination #2 ____/____/____ ☐ Unknown

- Dose administered:_____
- Vaccine type:_____
- Manufacturer:_____
- Product/trade name:_____
- Lot number:_____

Date of vaccination #3 ____/____/____ ☐ Unknown

- Dose administered:_____
- Vaccine type:_____
- Manufacturer:_____
- Product/trade name:_____
- Lot number:_____

Date of vaccination #4 ____/____/____ ☐ Unknown

- Dose administered:_____
- Vaccine type:_____
- Manufacturer:_____
- Product/trade name:_____
- Lot number:_____

Date of vaccination #5 ____/____/____ ☐ Unknown

- Dose administered:_____
- Vaccine type:_____
- Manufacturer:_____
- Product/trade name:_____
- Lot number:_____

If yes, number of doses received prior to illness: _____

If no, reason for inadequate vaccination:

- ☐ Religious exemption
- ☐ Medical exemption
- ☐ Medical contraindication
- ☐ Philosophical exemption (outside NC only)
- ☐ Laboratory evidence of previous disease
- ☐ Physician diagnosis of previous disease
- ☐ Under age for vaccination
- ☐ Parental refusal
- ☐ Missed opportunities
- ☐ Unknown
- ☐ Other, specify:_____

Total number of simultaneous injections at the time of polio vaccination:_____

Injection(s) 30 days prior to illness onset:

First vaccine injection (mm/dd/yyyy):_____

Injection site:

- ☐ Left deltoid
- ☐ Right deltoid
- ☐ Left thigh
- ☐ Right thigh
- ☐ Left gluteal
- ☐ Right gluteal

Second vaccine injection (mm/dd/yyyy):_____

Injection site:

- ☐ Left deltoid
- ☐ Right deltoid
- ☐ Left thigh
- ☐ Right thigh
- ☐ Left gluteal
- ☐ Right gluteal

Third vaccine injection (mm/dd/yyyy):_____

Injection site:

- ☐ Left deltoid
- ☐ Right deltoid
- ☐ Left thigh
- ☐ Right thigh
- ☐ Left gluteal
- ☐ Right gluteal

Fourth vaccine injection (mm/dd/yyyy):_____

Injection site:

- ☐ Left deltoid
- ☐ Right deltoid
- ☐ Left thigh
- ☐ Right thigh
- ☐ Left gluteal
- ☐ Right gluteal

Source of vaccine information:

- ☐ Patient's or Parent's verbal report
- ☐ Physician
- ☐ Medical record *(Note: Any vaccine on a medical record should be recorded in the NCIR)*
- ☐ Certificate of immunization record *(Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)*
- ☐ Patient vaccine record
- ☐ School record
- ☐ Other, specify:_____
- ☐ Unknown
- ☐ NCIR

Did patient have contact with OPV recipient? ☐ Y ☐ N ☐ U

Date(s) of contact:_____

_____

Did patient have contact with IPV recipient? ☐ Y ☐ N ☐ U

First date contact received IPV: _____

Second date contact received IPV: _____

Third date contact received IPV: _____

Fourth date contact received IPV:_____

Lot number of most recent dose: _____

REASON FOR TESTING

Why was the patient tested for this condition?

- ☐ Symptomatic of disease
- ☐ Screening of asymptomatic person with reported risk factor(s)
- ☐ Exposed to organism causing this disease (asymptomatic)
- ☐ Household / close contact to a person reported with this disease
- ☐ Other, specify_____
- ☐ Unknown

PREDISPOSING CONDITIONS

HIV/AIDS ☐ Y ☐ N ☐ U

Immunosuppressive conditions (not including HIV/AIDS) ☐ Y ☐ N ☐ U

Other underlying illness ☐ Y ☐ N ☐ U

Please specify: _____

Was the patient receiving any of the following treatments or taking any medications?

Antibiotics ☐ Y ☐ N ☐ U

For what medical condition?

_____

Chemotherapy ☐ Y ☐ N ☐ U

If yes, was therapy within the last 30 days before this illness? ☐ Y ☐ N ☐ U

For what medical condition?

_____

CONTINUED

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

PREDISPOSING CONDITIONS CONTINUED

Radiotherapy ☐Y ☐N ☐U
If yes, was therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?
_____

Systemic steroids/corticosteroids, including steroids taken by mouth or injection ☐Y ☐N ☐U
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?
_____

Immunosuppresive therapy, including anti-rejection therapy ☐Y ☐N ☐U
If yes, specify: _____
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?
_____

Aspirin or aspirin-containing product ☐Y ☐N ☐U
If yes, specify:
_____
If yes, was medication taking within the last 30 days before this illness? ☐Y ☐N ☐U
For what conditions?:
_____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐Y ☐N
Check all that apply:
☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify
_____

Date control measures issued: _____
Date control measures ended: _____
Was patient compliant with control measures? ☐Y ☐N

Local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐Y ☐N
If yes, specify: _____
_____

Were written isolation orders issued? ☐Y ☐N
If yes, where was the patient isolated? _____
_____
Date isolation started? _____
Date isolation ended? _____
Was the patient compliant with isolation? ☐Y ☐N

Were written quarantine orders issued? ☐Y ☐N
If yes, where was the patient quarantined?
_____
Date quarantine started? _____
Date quarantine ended? _____
Was the patient compliant with quarantine? ☐Y ☐N

Notes:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐Y ☐N ☐U
Name of care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____

Patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____

Patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____

Is patient a student? ☐Y ☐N ☐U
Type of school:
☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____
Specify grade: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U
Type of school
☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Telephone: (_____) _____

Notes:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 35 days prior to onset of symptoms until 6 weeks after onset of illness did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐Y ☐N ☐U
Name of facility: _____
Dates of contact: _____

During the 35 days prior to onset of symptoms until 6 weeks after onset of illness, did the patient attend social gatherings or crowded settings? ☐Y ☐N ☐U
If yes, specify: _____

In what setting was the patient most likely exposed?

☐ Restaurant
☐ Home
☐ Work
☐ Child Care
☐ School
☐ University/College
☐ Camp
☐ Doctor's office/ Outpatient clinic
☐ Hospital In-patient
☐ Hospital Emergency Department
☐ Laboratory
☐ Long-term care facility /Rest Home
☐ Military
☐ Prison/Jail/Detention Center
☐ Place of Worship
☐ Outdoors, including woods or wilderness
☐ Athletics
☐ Farm
☐ Pool or spa
☐ Pond, lake, river or other body of water
☐ Hotel / motel
☐ Social gathering, other than listed above
☐ Travel conveyance (airplane, ship, etc.)
☐ International
☐ Community
☐ Other (specify)
_____
☐ Unknown

Does the patient have any other risk factors for this disease? ☐Y ☐N ☐U
Specify: _____

TREATMENT

Did patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U
If yes, specify antibiotic name: _____
Treatment location:
☐ Outpatient
☐ Inpatient
☐ Unknown
Date antibiotic began (mm/dd/yyyy): _____
Date antibiotic ended (mm/dd/yyyy): _____
Number of days taken: _____ Unknown

Has the patient ever received immune globulin? ☐Y ☐N ☐U
When was the last dose received?
(mm/dd/yyyy): _____

Did the patient receive medical care for this illness? ☐Y ☐N ☐U
Specify level(s) of care (check all that apply):
☐ Outpatient
☐ Emergency department
☐ Inpatient
☐ ICU
☐ Other
☐ Unknown

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 35 days prior to onset of symptoms until 6 weeks after onset of illness, did the patient have any of the following health care exposures?

Emergency Dept. (not hospitalized)... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Hospital ..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):_____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

LTC facility—resident..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):_____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Outpatient facility—patient..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Visitor to health care setting ..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):_____
- Until date (mm/dd/yyyy):_____
- Frequency:
  ☐ Once
  ☐ Multiple times within this time period
  ☐ Daily
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Was patient pregnant while traveling? ..... ☐ Y ☐ N ☐ U
- If yes, was travel during the first trimester of pregnancy? ..... ☐ Y ☐ N ☐ U

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ..... ☐ Y ☐ N ☐ U

Name: _____

Notes:

Worked or volunteered in health care or clinical setting ..... ☐ Y ☐ N ☐ U
- Facility name_____
- City_____State _____
- Country _____
- Occupation:
  ☐ Physician
  ☐ Physician's assistant or nurse practitioner
  ☐ Nurse
  ☐ Laboratory
  ☐ Other
  ☐ Unknown
- Specify work setting or volunteer duties:
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Other, specify_____

Has the patient ever worked in a healthcare or clinical laboratory setting? ..... ☐ Y ☐ N ☐ U
- If yes, specify and give details: _____

During the timeframe displayed above, has the patient had other blood and body fluid exposures?..... ☐ No ☐ Other ☐ Unknown

Human saliva/oral secretions exposure (e.g. shared water bottle, cigarettes, eating utensils, kissing)**?**..... ☐ Y ☐ N ☐ U
- Specify and give details:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U
- Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others?..... ☐ Y ☐ N ☐ U
- Who was interviewed?

Were health care providers consulted?..... ☐ Y ☐ N ☐ U
- Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
- City _____
- County_____

☐ Outside NC, but within US
- City _____
- State _____
- County_____

☐ Outside US
- City _____
- Country _____

☐ Unknown

Notes:

TRAVEL

Was patient pregnant while traveling? ☐ Y ☐ N ☐ U

If yes, was travel during the first trimester of pregnancy? ..... ☐ Y ☐ N ☐ U

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ..... ☐ Y ☐ N ☐ U

Poliomyelitis, Paralytic

2010 Case Definition

CSTE Position Statement Number: 09-ID-53

Case classification

Probable: Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss.

Confirmed:
Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss; AND in which the patient:

- has a neurologic deficit 60 days after onset of initial symptoms; or
- has died; or
- has unknown follow-up status.

Comment

All suspected cases of paralytic poliomyelitis are reviewed by a panel of expert consultants before final classification occurs. Confirmed cases are then further classified based on epidemiologic and laboratory criteria[1]. Only confirmed cases are included in Table I in the MMWR. Suspected cases are enumerated in a footnote to the MMWR table.

References

1. Sutter RW, Brink EW, Cochi SL, et al. A new epidemiologic and laboratory classification system for paralytic poliomyelitis cases. Am J Public Health 1989;79:495-8.