health
Department:
Health
REPUBLIC OF SOUTH AFRICA

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

SOUTH AFRICA CASE INVESTIGATION FORM: ACUTE FLACCID PARALYSIS (AFP) 2023

EPID Number: **SOA**-_____-_____-_____-_____ *Received by the Programme at National level* _____/_____/_____
Country Prov. District Yeart Case Number

IDENTIFICATION

District:_____ Province: _____ Reporting Health Facility: _____

Patient Address:_____ Village:_____ City: _____

Patient name: _____ Father/Mother/Caregiver:_____ Contact details :_____

Date of Birth (DOB)____/_____/_____ Age: _____ years _____months (If DOB Unknown) Sex: ☐ M=Male F=Female

AFP case coordinates (*WGS 1984 format*): Longitude:_____ Latitude:_____

NOTIFICATION/INVESTIGATION:

Notified by:_____ Contact details_____ Date of Notification____/_____/_____ Date of Investigation: ____/_____/_____

HOSPITALIZATION

Hospitalized: ☐ 1=Y, 2=N Date of admission , if applicable: _____/_____/_____

Hospital record #:_____ Hospital Address:_____

CLINICAL HISTORY

Fever at the onset of paralysis? ☐ 1=Y, 2=N, 99=Unknown

Progressive Paralysis ≤ 3 days? ☐ 1=Y, 2=N, 99=Unknown

LA ☐☐ RA
LL ☐☐ RL

Date of onset: of paralysis: ____/_____/_____

Is Paralysis flaccid and acute? ☐ 1=Y, 2=N, 99=Unknown

Asymmetric? ☐ 1=Y, 2=N, 99=Unknown

Site of Paralysis

Paralyzed limb (s) Sensitive to pain: **Yes/No**
Was there any injection administered just before onset of paralysis: **Yes/No**
If yes mention the site of injection in the table:

	Arm	Fore-arm	Buttock	Thigh	Leg
Right					
Left					

PROVISIONAL DIFFERENTIAL DIAGNOSIS----------
(Please provide PROVISIONAL DIFFERENTIAL diagnosis. AFP does not constitute a diagnosis)

IMMUNIZATION HISTORY

Oral Polio (OPV) and IPV (Hexavalent) Doses

Total Number of Polio vaccine doses ☐ Exclude dose at birth
99=Unknown

OPV dose at birth _____/_____/____ 1st _____/_____/____ 2nd ____/_____/____
If > 4
3rd _____/_____/____ 4th _____/_____/____ Last _____/_____/____ dose

Total OPV doses received through SIA: ☐ 99=Unknown Total OPV doses received through RI: ☐ 99=Unknown.

Date of last OPV dose received through SIA: _____/_____/____

Total IPV doses received through SIA: ☐ 99=Unknown Total IPV doses received through RI: ☐ 99=Unknown

Date of last IPV dose received through SIA: ____/____/_____ Source of RI vaccination information: Card ☐ Recall ☐

AFP CASES TO BE NOTIFIED BY PHONE; PROVINCIAL CONTACT PERSON: Name& Phone:_____
IMMEDIATELY SEND A COPY OF THIS COMPLETED FORM TO: Name& Phone:_____
IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT EXPANDED PROGRAMME ON IMMUNISATION (EPI) NATIONAL OFFICE 012 395 8335/012 395 8380

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STOOL SPECIMEN COLLECTION:

_____/_____/_____ Date 1st specimen

_____/_____/_____ Date 2nd specimen

_____/_____/_____ Date specimen sent to the to the national level

_____/_____/_____ Date specimen received at the national level

_____/_____/_____ Date specimen sent inter-county/national Laboratory

STOOL SPECIMEN RESULTS:

____/_____/_____ Date specimen received at inter country (I-C)/national Lab

☐ 1= Adequate 2=Not adequate
Status of specimen at Reception at the lab

___/_____/_____ Date combined Cell Culture Results available

____/_____/_____ Date Results sent to national EPI

____/_____/_____ Date Results received at national EPI

Final cell Culture Results ☐
1=Suspected poliovirus
2= Negative
3=NPENT
4=Suspect poliovirus + NPENT

____/_____/_____ Date sent from I-C/National Laboratory to regional lab

____/_____/_____ Date I-T differentiation results sent to EPI

____/_____/_____ Date I-T differentiation results received at EPI

Final Lab Results

W1	W2	W3	Discordant Sabin	SL1	SL2	SL3	(R) NPENT	NEV
☐	☐	☐	☐	☐	☐	☐	☐	☐
1=Y, 2=N			Type 1,2,3	1=Y, 2=N			1=positive, 2=Negative	

____/_____/_____ Date isolate sent for sequencing

____/_____/_____ Date seq results sent to program

60-Day FOLLOW-UP EXAMINATION

____/_____/_____ Date of follow-up exam.

Residual Paralysis? LA ☐ ☐ RA / LL ☐ ☐ RL

Results of exam ☐
1 = Residual Flaccid Paralysis
2=No residual paralysis
3= Lost to follow-up
4=Died before follow-up
5= Residual Spastic Paralysis

Immunocompromised status suspected: ☐ 1=Y, 2=N, 99=Unknown

FINAL CLASSIFICATION

☐ 1=Confirmed Polio
2=Compatible
3=Discarded
6=Not an AFP case

☐ 7=cVDPV
8=aVDPV
9=iVDPV

☐ Sero-type (1, 2, 3)

Fill in this section before signing the form

Where has the child been seeking help for this problem before presenting at present place (in sequence of visits)?

(1). Place: _____ Duration: months_____ days____ (2) Place:_____ Duration: months_____ days____

(3). Place: _____ Duration: months_____ days____ (4) Place:_____ Duration: months_____ days____

INVESTIGATOR: Name_____ Title_____

Unit:_____ Address_____ Tel:_____

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NEUROLOGICAL ASSESSMENT FORM FOR ALL ACUTE FLACCID PARALYSIS (AFP) CASES

<table>
<tr><td>1</td><td>EPID number</td><td colspan="4">SOA--_____--_____--_____--_____
Country Province District Year Case number</td></tr>
<tr><td colspan="6">IDENTIFICATION</td></tr>
<tr><td>2</td><td>Province</td><td colspan="4"></td></tr>
<tr><td>3</td><td>District</td><td colspan="4"></td></tr>
<tr><td>4</td><td>Name of AFP case</td><td colspan="4"></td></tr>
<tr><td>5</td><td>Date of Birth</td><td colspan="4"></td></tr>
<tr><td>6</td><td>Onset of paralysis</td><td colspan="4"></td></tr>
<tr><td colspan="6">NEUROLOGICAL EXAMINATION</td></tr>
<tr><td>7</td><td>Glasgow Coma Scale</td><td colspan="4"><table><tr><td>Eye Opening (4)</td><td></td></tr><tr><td>Verbal Response (5)</td><td></td></tr><tr><td>Motor Response (6)</td><td></td></tr><tr><td>SCORE (15)</td><td></td></tr></table></td></tr>
<tr><td>8</td><td>Power (0-5)
0 = No movement
1 = Flicker
2 = Gravity eliminated
3 = Against gravity
4 = Just below normal
5 = Normal for age</td><td colspan="4"><table><tr><td colspan="2">Upper Limb</td><td colspan="2">Lower Limb</td></tr><tr><td>Right</td><td>Left</td><td>Right</td><td>Left</td></tr><tr><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>9</td><td>Tone (Normal/Increased/decreased)</td><td colspan="4"><table><tr><td colspan="2">Upper Limb</td><td colspan="2">Lower Limb</td></tr><tr><td>Right</td><td>Left</td><td>Right</td><td>Left</td></tr><tr><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>10</td><td>Reflexes (0-3)
0 = No reflexes
1 = Normal
2 = Brisk
3 = Brisk with clonus</td><td colspan="4"><table><tr><td colspan="2">Upper Limb</td><td colspan="2">Lower Limb</td></tr><tr><td>Right</td><td>Left</td><td>Right</td><td>Left</td></tr><tr><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>11</td><td>Sensation (intact/loss distribution/level)</td><td colspan="4"></td></tr>
<tr><td>12</td><td>Bowel control/continence
Normal/abnormal</td><td colspan="4"></td></tr>
<tr><td>13</td><td>Bladder control/continence
Normal/abnormal</td><td colspan="4"></td></tr>
<tr><td>14</td><td>Cerebellar signs
(present/none)</td><td colspan="4"></td></tr>
</table>

NAME OF EXAMINING DR:_____DATE OF EXAMINATION:_____

CONTACT DETAILS OF EXAMINING DR:_____SIGNATURE:_____

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