

Serial No.

AFP ID Code SRL////



**POLIO ERADICATION INITIATIVE  
ACUTE FLACCID PARALYSIS  
[AFP]/SUSPECTED POLIOMYELITIS  
FORM No. 2**

This case is to be investigated personally by the Medical Officer of Health and this form returned to EPIDEMIOLOGIST, EPIDEMIOLOGICAL UNIT, 231, DE SARAM PLACE, COLOMBO 01000 (Fax: 2696583, e-mail: [epidunit@sltnet.lk](mailto:epidunit@sltnet.lk), [chepid@sltnet.lk](mailto:chepid@sltnet.lk) with a copy to Regional Epidemiologist soon after the completion of the first round of immunization. PLEASE DO NOT WRITE IN THE SHADED AREAS.

**A. GENERAL**

1. MOH Area: \_\_\_\_\_ 1. .

2. DPDHS Area: \_\_\_\_\_ 2. .

3. This case was notified to you on 3. ..  
DD MM YYYY

4. Name of patient: \_\_\_\_\_

5. Residential Address: \_\_\_\_\_

6. Date of Birth: 6. ..  
DD MM YYYY

7. Sex: Male  Female

8. Ethnic Group: Sinhala  Tamil  Moor   
Other  Unknown

7.

8.

9.

9. Name of Hospital: \_\_\_\_\_

10. Date of Admission: 10. ..  
DD MM YYYY

11. Outcome: Still in hospital  Discharged  Died  11.

12. Date of discharge or death 12. ..

**B. IMMUNIZATION HISTORY:**

13. PHM Area: \_\_\_\_\_

14. Population of PHM Area: 14.

15. Percentage immunization coverage with OPV3 in this PHM area in 15.   
.%

16. Immunization status of patient (OPV)

		DD	MM	YYYY
16.1. First dose given on:	16.1.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
16.2. Second dose given on:	16.2.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
16.3. Third dose given on:	16.3.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
16.4. Fourth dose given on:	16.4.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
16.5. Fifth dose given on:	16.5.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
16.6. Others:	16.6.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**C. PROBABLE SOURCE OF INFECTION**

17. Contact with another AFP/Polio patient within 60 days of onset of paralysis?

Yes  No  Unknown

19.

18. If "Yes" for 17, name and address of this other patient:

\_\_\_\_\_

19. Date of contact:

19. ..  
DD MM YYYY

20. Travel outside the MOH area, within 28 days prior to the onset of paralysis?

Yes  No  Unknown

20.

**D. CONTACTS**

21. Particulars of contacts from whom stool samples were collected (siblings and playmates):

21.

Name	Age	Sex	Dates of collection of stools			Polio Immunization (Date of last dose)		
			DD	MM	YYYY	DD	MM	YYYY
1.								
2.								
3.								
4.								
5.								

**E. OUTBREAK RESPONSE:**

	DD	MM	YYYY
22. Investigation and control measures initiated on:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
23. First (extra) dose of immunization given on:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
24. No. of 1 <sup>st</sup> (extra) doses of OPV given:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
25. Remarks:	_____		

Name of MOH/DDHS:..... Signature of MOH/DDHS: .....

Date ..

\*Copy to Regional Epidemiologist.