**ACUTE FLACCID PARALYSIS INITIAL QUESTIONNAIRE (Revised May 2020)**

**Australian Paediatric Surveillance Unit – Victorian Infectious Diseases Reference Laboratory**
Enquiries Dr Bruce Thorley at VIDRL ph: (03) 9342 9607 to discuss this questionnaire or Prof Elizabeth Elliott on (02) 9845 3005 for clinical queries.
Please return questionnaire to: AFP Surveillance, Victorian Infectious Diseases Reference Laboratory, The Doherty Institute, 792 Elizabeth Street, Melbourne, Victoria 3000 fax: (03) 9342 9655 email: enterovirus@mh.org.au

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If this patient is primarily cared for by another physician who you believe will report the case, please complete the reporting clinician and patient details only and return to VIDRL. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire. The primary clinician caring for this child is: Name: Hospital:

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**REPORTING CLINICIAN’S DETAILS**

<table>
<thead>
<tr>
<th>1. APSU Dr Code</th>
<th>2. Month/Year of Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Dr Name</td>
<td>4. Dr Address</td>
</tr>
<tr>
<td>5. Dr Telephone</td>
<td>Fax: ( ) Email</td>
</tr>
</tbody>
</table>

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**PATIENT DETAILS**

6. First 2 letters of Surname 7. First 2 letters of Given Name 8. Hospital Of Admission

9. Date of Birth: / / 10. Sex Male Female Unsure

11. Postcode 12. Of Aboriginal/Torres Strait Islander descent? Yes No Unsure

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**PATIENT VACCINATION HISTORY**

13. Has the patient ever been immunised with a vaccine including polio? Yes ACIR/written record; Yes self-report; No Unknown

14. Number of doses? If known, date of last dose Date / / Unknown

15. Has the patient been in contact with someone who received oral polio vaccine within the 6 weeks prior to onset of symptoms? Yes No Unsure

16. Has the child travelled overseas in the last 3 months? Yes No Unsure. If yes, specify where

17. Has the patient had contact with anyone who has travelled overseas OR visited from overseas in the last 3 months? Yes No Unsure. If yes, specify country of travel or origin and relationship to patient

18. In the 6 weeks prior to presentation, did the child;

   a) receive influenza vaccine? Yes No Unsure IF YES, type of vaccine: Date given / / Date given / /

   b) receive any other vaccine? Yes No Unsure IF YES, which vaccine(s): Date given / / Date given / /

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**CLINICAL FEATURES & INVESTIGATIONS**

19. Date of onset of paralysis (dd/mm/yy) / / 20. Site of paralysis

21. In the 6 weeks prior to presentation, did the child;

   a) have an influenza-like illness? Yes No Unsure IF YES, please describe symptoms:

   b) was the child tested for influenza? Yes No Unsure IF YES, result:

      IF POSITIVE Date of positive specimen / /

22. In the 6 weeks prior to presentation, did the child have any other infective illness? Yes No Unsure IF YES, a) please describe symptoms:

   b) did the child have laboratory testing? Yes No Unsure IF YES, result:

      IF POSITIVE Date of positive specimen / /

23. Was the patient encephalopathic? Yes No Unsure

   Encephalopathy is defined as an alteration in consciousness (e.g. stupor, lethargy) or behavioural change unexplained by fever, systemic illness or postictal symptoms.

24. Was the patient hospitalised? Yes No Unsure

25. Was the patient immunosuppressed? Yes No Unsure IF YES, specify

26. Was a sensory level detected on examination? Yes No Unsure IF YES, specify

27. Was there cranial nerve involvement? Yes No Unsure IF YES, specify

28. Was there bladder and/or bowel involvement? Yes No Unsure IF YES, specify (e.g. Urinary retention/incontinence)

29. Was a lumbar puncture performed? Yes No Unsure

30. IF YES, CSF: protein (g/L), glucose (mmol/L), WBC (x10^9/L); Number of PMN (x10^9/L); Lymphocyte (x10^9/L); RBC (x10^9/L); other

31. Were nerve conduction studies and/or EMG performed? Yes No Unsure IF YES, specify results

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32. Was any neuroimaging performed?  
IF YES, MRI of brain  
CT of brain  
MRI of spine  
CT of spine

33. Were stool specimens collected for testing at VIDRL?  
IF YES, how many stool specimens were collected?

34. Did the patient survive the illness?  
IF NO, please give number of days between onset of paralysis and death

35. Does the patient have any residual motor deficits/paralysis?  
IF YES, specify

36. Does the patient have residual sensory deficits?  
IF YES, specify

37. Is there residual sphincter dysfunction?  

DIAGNOSIS

38. In light of currently available evidence, what is the patient’s diagnosis? (Please indicate on list below)

<table>
<thead>
<tr>
<th>Peripheral neuropathy</th>
<th>Acute myelopathy</th>
<th>Systemic disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Guillain-Barré syndrome (acute post-infectious polyneuropathy)</td>
<td>□ Transverse myelitis</td>
<td>□ Acute porphyria</td>
</tr>
<tr>
<td>□ Acute axonal neuropathy</td>
<td>□ Acute disseminated encephalomyelitis (ADEM)</td>
<td>□ Critical illness neuropathy/myopathy</td>
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<tr>
<td>□ Neuropathies of infectious diseases</td>
<td>□ Spinal cord ischaemia</td>
<td>□ Conversion disorder</td>
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<tr>
<td>□ Acute toxic neuropathies (heavy metals)</td>
<td>□ Spinal cord injury or compression eg. Tumour, trauma</td>
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<tr>
<td>□ Focal mononeuropathy</td>
<td>□ Peri-operative complication</td>
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</tr>
<tr>
<td>Anterior horn cell disease</td>
<td>Muscle disorders</td>
<td>Disorders of neuromuscular transmission</td>
</tr>
<tr>
<td>□ Acute poliomyelitis</td>
<td>□ Polymyositis, dermatomyositis</td>
<td>□ Botulism</td>
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<tr>
<td>□ Vaccine-associated poliomyelitis</td>
<td>□ Periodic paralyses</td>
<td>□ Insecticide e.g.: organophosphate poisoning</td>
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<tr>
<td>□ Other neurotropic viruses</td>
<td>□ Mitochondrial diseases (infantile type)</td>
<td>□ Tick bite paralysis</td>
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<tr>
<td></td>
<td>□ Viral myositis</td>
<td>□ Myasthenia gravis</td>
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<td></td>
<td>□ Drug-induced paralysis (specify)</td>
<td>□ Snake bite</td>
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<td></td>
<td></td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

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