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

**Australian Paediatric Surveillance Unit – Victorian Infectious Diseases Reference Laboratory**

**Enquires 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 9665 email:** **enterovirus@mh.org.au**

**For information regarding referral of specimens to VIDRL please see**[**http://www.vidrl.org.au/surveillance/afp-surveillance1/**](http://www.vidrl.org.au/surveillance/afp-surveillance1/)

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:***

**REPORTING CLINICIAN’S DETAILS**

**1.** APSU Dr Code: \_\_ \_\_ \_\_ \_\_ **2**. Date form completed: \_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_

**3.** Dr Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **4.** Dr Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.** Dr Telephone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S 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 of family: | \_\_\_ \_\_\_ \_\_\_ \_\_\_  |
| **12.** Of Aboriginal/Torres Strait Islander descent? | □ Yes □ No □ Unsure |

**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: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_ □ 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?***If Yes*,** specify where: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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?***If Yes***, type of vaccine:Date given: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_  |
| **b)** receive any other vaccine?***If Yes***, type of vaccine:Date given: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_  |
| **CLINICAL FEATURES & INVESTIGATIONS** |
| **19.** Date of onset of paralysis: | \_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_  |
| **20.** Site of paralysis: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **21.** In the 6 weeks prior to presentation, did the child; |  |
| **a)** have an influenza-like illness?***If Yes***, please describe symptoms: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **b)** was the child tested for influenza?***If Yes***, result:***If POSITIVE,*** date of positive specimen: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_  |
| **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?***If Yes***, result:***If POSITIVE***, date of positive specimen: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_  |
| **23.** Was the patient encephalopathic?*Encephalopathic is defined as an alteration in consciousness (e.g. stupor, lethargy) or behavioural change unexplained by fever, systemic illness or postictal symptoms.* | □ Yes □ No □ Unsure |
| **24.** Was the patient hospitalised? | □ Yes □ No □ Unsure |
| **25.** Was the patient immunosuppressed?***If Yes***, specify: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **26.** Was a sensory level detected on examination? ***If Yes***, specify: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **27.** Was there cranial nerve involvement?***If Yes***, specify: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **28.** Was there bladder and/or bowel involvement?*(e.g. Urinary retention/incontinence)****If Yes***, specify: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **29.** Was a lumbar puncture performed? | □ Yes □ No □ Unsure |
| **30.** ***If Yes***, CSF:Protein:Glucose:WBC:Number of PMN:Lympohocyte:RBC:Other: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ g/L\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mmol/L\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (x106/L)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (x106/L)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (x106/L)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (x106/L)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **31.** Were nerve conduction studies and/or EMG performed? | □ Yes □ No □ Unsure |
| ***If Yes***, specify results: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **32.** Was any neuroimaging performed? | □ Yes □ No □ Unsure |
| ***If Yes***, MRI of brain:CT of brain:MRI of spine:CT of spine: | □ Yes □ No ***If yes***, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Yes □ No ***If yes***, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Yes □ No ***If yes***, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Yes □ No ***If yes***, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **33.** Were stool specimens collected for testing at VIDRL?***If Yes***, how many stool specimens were collected? | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **OUTCOME** |
| **34.** Did the patient survive the illness?***If No***, please give number of days between onset of paralysis and death | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| **35.** Does the patient have any residual motor deficits/paralysis?***If No***, duration of paralysis?***If Yes***, specify: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **36.** Does the patient have residual sensory deficits?***If Yes***, specify: | □ Yes □ No □ Unsure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **37.** Is there residual sphincter dysfunction? | □ Yes □ No □ Unsure |
| **DIAGNOSIS**  |
| **38.** In light of currently available evidence, what is the patient’s diagnosis? (Please indicate on list below) |

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