California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Immunization Branch
850 Marina Bay Parkway Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Fax: (510) 620-3949

POLIOVIRUS INFECTION OR POLIOMYELITIS CASE REPORT

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

Census Tract	County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information
Work / School Location	Work / School Contact

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	If Yes, Est. Delivery Date (mm/dd/yyyy)
Medical Record Number	Patient's Parent/Guardian Name
Occupation Setting	Other Describe/Specify
Occupation	Other Describe/Specify

Primary Language
☐ English
☐ Spanish
☐ Other: ____________________

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 6)
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.
☐ American Indian or Alaska Native
☐ Asian (check all that apply, see list on page 6)
☐ Asian Indian ☐ Korean
☐ Bangladeshi ☐ Laotian
☐ Cambodian ☐ Malaysian
☐ Chinese ☐ Pakistani
☐ Filipino ☐ Sri Lankan
☐ Hmong ☐ Taiwanese
☐ Indonesian ☐ Thai
☐ Japanese ☐ Vietnamese
☐ Other: ____________________
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 6)
☐ Native Hawaiian ☐ Samoan
☐ Fijian ☐ Tongan
☐ Guamanian
☐ Other: ____________________
☐ White
☐ Other: ____________________
☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

CLINICAL INFO

Signs and Symptoms

Weakness or Paralysis ☐ Yes ☐ No ☐ Unknown	Weakness / Paralysis Onset Date ☐ Yes ☐ No ☐ Unknown
Was there paralysis or muscle weakness 60 days after onset? ☐ Yes ☐ No ☐ Unknown	If yes, describe:
Describe symptoms, signs (fever, gastrointestinal symptoms, meningeal irritation, myalgia; type—flaccid vs. plastic / rigid—distribution and progress of paralysis)	
Did patient die? ☐ Yes ☐ No ☐ Unknown	If yes, date of death (mm/dd/yyyy)
Attending / Consulting Physician	Telephone Number

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unknown	Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown
How many total hospital nights? ☐ Yes ☐ No ☐ Unknown	During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? ☐ Yes ☐ No ☐ Unknown

HOSPITALIZATION – DETAILS

Hospital Name	City	State	ZIP Code	Telephone

Admit Date (mm/dd/yyyy)	Discharge Date (mm/dd/yyyy)	Medical Record Number
Discharge Diagnosis		

VACCINATION HISTORY

Date (mm/dd/yyyy)	Type of Vaccine Administered
Manufacturer	Lot Number
Date (mm/dd/yyyy)	Type of Vaccine Administered
Manufacturer	Lot Number

REASON NOT VACCINATED:

☐ Personal Beliefs Exemption (PBE) ☐ Permanent Medical Exemption (PME) ☐ Temporary Medical Exemption ☐ Lab confirmation of previous disease
☐ MD diagnosis of previous disease ☐ Under age for vaccination ☐ Delay in starting series or between doses ☐ Unknown ☐ Other

MEDICAL HISTORY

Immunocompromised ☐ Yes ☐ No ☐ Unknown
Other Pre-existing Conditions

LABORATORY INFORMATION

NOTIFICATION – IF POLIOVIRUS IS ISOLATED FROM ANY SOURCE
CONTACT CDPH IMMUNIZATION BRANCH IMMEDIATELY:
PHONE: 510-620-3737
E-MAIL: VPDREPORT@CDPH.CA.GOV

LABORATORY RESULTS SUMMARY			
Case Lab Confirmed ☐ Yes ☐ No ☐ Unknown			
Type of Test	Type of Specimen	Test Result	Date Collected (mm/dd/yyyy)
Type of Test	Type of Specimen	Test Result	Date Collected (mm/dd/yyyy)
Type of Test	Type of Specimen	Test Result	Date Collected (mm/dd/yyyy)
Type of Test	Type of Specimen	Test Result	Date Collected (mm/dd/yyyy)
Notes on Laboratory Tests			

Incubation Period

INCUBATION PERIOD FOR NONPARALYTIC POLIOMYELITIS IS 6 DAYS PRIOR TO ILLNESS ONSET;

INCUBATION PERIOD FOR PARALYTIC POLIOMYELITIS IS 21 DAYS ILLNESS ONSET

TRAVEL HISTORY	
Did patient travel during the incubation period? ☐ Yes ☐ No ☐ Unknown	Did the patient have contact with travelers or visitors during the incubation period? ☐ Yes ☐ No ☐ Unknown

PATIENT'S TRAVEL INFORMATION		
Country of Residence		
☐ United States	☐ Other, specify:	Date of U.S. Arrival (mm/dd/yyyy):
History of International Travel (two weeks prior to the onset) ☐ Yes ☐ No ☐ Unknown		
If yes, please provide the following information:		
State or Country Visited	**Month/Day/Year**	**Month/Day/Year**
1.	From:	To:
2.	From:	To:
3.	From:	To:
4.	From:	To:
5.	From:	To:

FLIGHT INFORMATION

Did patient fly while infectious?

☐ Yes ☐ No ☐ Unknown

Airline(s)	Flight Number(s)
Departure Date (mm/dd/yyyy)	Arrival Date (mm/dd/yyyy)

CONTACTS

Contact with person who received OPV ≤ 75 days before onset of case's symptoms

☐ Yes ☐ No ☐ Unknown

Other cases of polio-like illness in the community or in contact with the case ≤ 30 days before onset

☐ Yes ☐ No ☐ Unknown

CASE DEFINITION (2023)

Clinical Criteria:

Acute onset of flaccid paralysis with decreased or absent tendon reflexes in the affected limbs, in the absence of a more likely alternative diagnosis.

Laboratory Criteria:

Confirmatory Laboratory Evidence:

- Poliovirus detected by sequencing of the capsid region of the genome by the CDC Poliovirus Laboratory,
  OR
- Poliovirus identified in an appropriate clinical specimen (e.g., stool [preferred], cerebrospinal fluid, oropharyngeal secretions) using a properly validated assay
- **AND** specimen is not available for sequencing by the CDC Poliovirus Laboratory.

Case Classification

Confirmed

Paralytic Poliomyelitis: Meets clinical criteria AND confirmatory laboratory evidence.

Nonparalytic Poliovirus Infection: Meets confirmatory laboratory evidence.

Investigator name (print)	Telephone number
Agency Name	
Date	

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	