Case Report Form *(V. 21.12.17)*

PARTICIPANT IDENTIFICATION NUMBER	Interviewer Initials:	LAB SAMPLE LABEL
[__][__][__] - [__][__][__] - [__][__][__]		

Health Facility: _____

Interview Date [___][___]/[___][___]/[_2_][_0_][___][___]

Sample, and date taken (*dd/mm/yyyy*)

☐ Blood [___][___]/[___][___]/[_2_][_0_][__][__]

☐ Swab [___][___]/[___][___]/[_2_][_0_][__][__]

1. PERSONAL INFORMATION *Complete at presentation/admission*

Patient First Name: _____ **Last Name:** _____

SEX: ☐ Male ☐ Female **AGE**: [___][___][___] years **OR** [___][___] months (if < 3 years)

Address *(as detailed as possible)* **STATE** _____

LOCALITY _____

VILLAGE _____

Telephone No. _____

Is the information given by family member or proxy decision-maker? NO YES *[circle]*

Name of proxy_____ **Relationship**_____

Information checked later with patient? NO YES *[circle]*

2. ADMISSION INFORMATION *Complete at presentation/admission*

Date of consultation in /admission to this facility(*DD/MM/YYYY*)**:** [___][___]/[___][___]/[_2_][_0_][___][___]

Date of symptom onset(*DD/MM/YYYY*)**:** [___][___]/[___][___]/[_2_][_0_][___][___]

NUMBER OF DAYS ILL including today: [___][___] days

TRANSFERED FROM another health facility? YES NO UNKNOWN *[circle]*

If YES: **Name of transferring facility**: _____**Location**_____

Date admitted to transfer facility): [___][___]/[___][___]/[_2__][_0__][___][___] ☐ Unknown

Is the Patient PREGNANT? YES NO UNKNOWN Not Applicable *[circle]*

If YES, **trimester:** ONE TWO THREE *[circle]*

Has the Patient recently delivered (within 12 weeks)? YES NO Not Applicable *[circle]*

If YES: **Outcome of Pregnancy:** LIVE BIRTH STILL BIRTH MISCARRIAGE UNKNOWN *[circle]*

Days/weeks since delivery? [___][___] days **OR** [___] weeks

Is Patient breast-feeding: YES NO UNKNOWN *[circle]*

Is the Baby also ill? YES NO YES/OTHER UNKNOWN **Baby Study PIN**.[__][__][__] - [__][__][__]

3. EXPOSURES

Complete with at presentation/admission or as soon as possible after.
Complete with patient as first choice. If not possible complete with family member

a. Patient occupation *(tick a MAXIMUM of two occupations)*

☐ Child/Pupil/Student ☐ Housewife ☐ Unemployed ☐ Retired

☐ Trader ☐ Labourer ☐ Professional/Business ☐ Teacher ☐ Community/religious leader

☐ Crop Farmer ☐ Animal Farmer (sheep, goats, cattle, camel) ☐ Butcher ☐ Hunter

☐ Health worker ☐ Traditional healer ☐ Traditional birth attendant

☐ Other _____ *(specify)*

b. Contact Factors: *(tick ALL answers mentioned. Tick NO if no exposure for that type of risk factor)*

In the past month has the patient:

1. **Taken part in:** ☐ a funeral ☐ cultural traditions ☐ NO
2. **Had close contact with a corpse or taken part in preparing the body** ☐ YES ☐ NO
3. **Cared for someone with an acute illness** (not chronic illness) ☐ YES ☐ NO
4. **Been exposed to someone else's blood or body fluids** ☐ YES ☐ NO
5. **Visited a:** ☐ Baseer ☐ Hijama ☐ Kay ☐ el Faki/ Foggera ☐ NO
6. **Had contact with:** ☐ Cows ☐ Sheep/Goat ☐ Camels ☐ Horses/donkeys ☐ Fowl/Birds ☐ Buffalo ☐ Rat ☐ Dog ☐ Cat ☐ Monkey ☐ NO
7. **Had contact with wild meat:** ☐ YES ☐ NO
8. **Bitten by:** ☐ Tick ☐ Lice ☐ NO
9. **Travelled away from home in the past month** ☐ YES ☐ NO ☐ Unknown

   If YES, 1st location_____ from_____ to_____(dates)

   2nd location _____from_____ to_____(dates)

c. Household Information

Number of: **Adults** [__][__] ☐Unknown **Children (<16y)** [__][__] ☐ Unknown

Type of house: ☐ Brick/Concrete ☐ Mud ☐ Tent ☐ Grass hut ☐ Unknown

Access to toilet: ☐ No access ☐ Family's own ☐ Shared toilet ☐ Unknown

Water source: ☐ Piped water ☐ Own well ☐ Well outside compound ☐ Unknown

Animals in household: ☐ YES ☐ NO ☐ Unknown

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[__][__][__] - [__][__][__] - [__][__][__]

4. SIGNS AND SYMPTOMS AT CONSULTATION/ADMISSION *(First available data. Complete within 24 hours if possible) Ask patient about the symptoms they have experience from the start of their illness until today.*

Temperature:[___][___][___].[___]°C *(Find these information in the medical chart)*

Heart rate:[___][___][___] beats per minute **Respiratory rate:** [___][___]breaths per minute

Blood Pressure:[___][___][___]/[___][___][___]mmHg *(Write Systolic BP/Diastolic BP)*

Clinically dehydrated? YES NO UNKNOWN

Signs and symptoms *(that have occurred with this episode of acute illness)*

History of fever	☐YES ☐NO ☐Unkn	**BLEEDING**	☐YES ☐NO ☐Unkn
Headache	☐YES ☐NO ☐Unkn	***If YES, specify site(s):***	
Fatigue/tiredness/lethargy	☐YES ☐NO ☐Unkn	Gums	☐YES ☐NO ☐Unkn
Muscle aches (myalgia)	☐YES ☐NO ☐Unkn	Mouth (palate)	☐YES ☐NO ☐Unkn
Joint pain (arthralgia)	☐YES ☐NO ☐Unkn	Nose	☐YES ☐NO ☐Unkn
Vomiting	☐YES ☐NO ☐Unkn	Eyes	☐YES ☐NO ☐Unkn
Diarrhoea	☐YES ☐NO ☐Unkn	Ears	☐YES ☐NO ☐Unkn
Difficulty swallowing	☐YES ☐NO ☐Unkn	Petechiae/Purpura	☐YES ☐NO ☐Unkn
Shortness of Breath	☐YES ☐NO ☐Unkn	Muscle Haematoma	☐YES ☐NO ☐Unkn
Loss of appetite	☐YES ☐NO ☐Unkn	Bloody sputum/ cough	☐YES ☐NO ☐Unkn
Abdominal pain	☐YES ☐NO ☐Unkn	Fresh red blood in vomit	☐YES ☐NO ☐Unkn
Hiccups	☐YES ☐NO ☐Unkn	Brown blood in vomit (coffee grounds)	☐YES ☐NO ☐Unkn
Red eyes	☐YES ☐NO ☐Unkn	Fresh red blood in stool	☐YES ☐NO ☐Unkn
Skin rash	☐YES ☐NO ☐Unkn	Melaena (black) blood in stool	☐YES ☐NO ☐Unkn
Dizziness	☐YES ☐NO ☐Unkn	Venepuncture sites	☐YES ☐NO ☐Unkn
Confusion	☐YES ☐NO ☐Unkn	Blood in Urine	☐YES ☐NO ☐Unkn
Seizures	☐YES ☐NO ☐Unkn	Vaginal (non-menstrual)	☐YES ☐NO ☐Unkn
Enlarged lymph nodes	☐YES ☐NO ☐Unkn	Back pain	☐YES ☐NO ☐Unkn
Cough	☐YES ☐NO ☐Unkn	Chest pain	☐YES ☐NO ☐Unkn
Sore throat	☐YES ☐NO ☐Unkn	Minor Bruising	☐YES ☐NO ☐Unkn
Jaundice	☐YES ☐NO ☐Unkn	Major bruising	☐YES ☐NO ☐Unkn

Any symptom not mentioned above:

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[__][__][__] - [__][__][__] - [__][__][__]

5. DAILY OBSERVATIONS AND TREATMENTS: *to be completed daily if admitted*

Record the most <u>abnormal</u> value for the each day of admission

Use the information in the medical chart

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
DATE: *dd/mm*	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _
Temperature *Record highest of day or NR*							
Lowest Consciousness* *Write : A, V, P or U or NR*							
Diarrhoea *Y/N/NR*							
Vomiting *Y/N/NR*							
Bleeding *Y/N/NR*							
If YES, **record where!** *if > 2 locations write in notes*							
Urine output (litres/day)							
Did the patient receive intravenous fluids in the past 24 hours?							
Intravenous fluids Y/N							
IF YES**: record volume** in litres/24 hours							

Any additional notes:

* Level of consciousness: mark highest/lowest AVPU level, where A is the highest and U is the lowest level

A(Patient is awake); **V** (Responds to verbal stimulation)

P(Responds to painful stimulation); **U** (Completely unresponsive)

NR : not recorded

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[__][__][__] - [__][__][__] - [__][__][__]

6. LABORATORY RESULTS: *to be completed daily if hospitalized – if more than 7 days, attach a second sheet.*

***** ONLY TESTS REQUIRED FOR STANDARD MANAGEMENT SHOULD BE DONE. STUDY TEAM MUST NOT ASK STAFF TO DO EXTRA TESTS. PATIENTS MUST NOT BE ASKED TO PAY FOR ANY ADDITIONAL TESTS "FOR THE STUDY"***

Mark the correct unit where indicated. If >1 test per day, use most abnormal value. If not done enter "ND".

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
DATE: *dd/mm*	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _	_ _ / _ _
Haemoglobin g/dL							
WBC count x10^3/µL							
Platelets x10^3/µL							
APTT							
PT (seconds)							
INR							
Blood Urea Nitrogen mg/d							
Glucose mg/dL							
Creatinine ☐mg/dL							
Bilirubin ☐mg/dL							
AST/SGOT U/L							
ALT/SGPT U/L							
Creatine kinase U/L							

Others (*specify test, date done and result)*

UFOS CASE REPORT FORM

STUDY PARTICIPANT IDENTIFICATION NUMBER:

[__][__][__] - [__][__][__] - [__][__][__]

COMPLETE THIS PAGE WHEN PARTICIPANT LEAVES THE HEALTH FACILITY

6. PARTICIPANT OUTCOME

***(choose only ONE outcome**: TICK the box, write the date or unknown)*

☐ **DISCHARGED** recovered

Date of discharge *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][___][____] ☐ Unknown

☐ **DIED in facility from disease of interest:**

Date of death: *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][___][____] ☐ Unknown

☐ **TRANSFERRED to another facility:**

If **YES**, name of new facility or location: _____ ☐ Unknown

Date of Transfer: *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][___][___] ☐ Unknown

☐ **LOST TO FOLLOW UP** (includes self-discharge/escape and family removal)

Date last seen: *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][____][____] ☐ Unknown

Tick this box if information about the participant's outcome has been received since patient left ☐

Enter this information in 30-day Follow-Up Form

☐ **WITHDRAWN from study**

Date of withdrawal: *(DD/MM/YYYY)* [___][___]/[____][____]/[__2__][__0__][___][___] ☐ Unknown date

Give reason: _____ ☐ Unknown reason

_____

Outcome information completed by (Name)_____

REMEMBER: to request that the participant return for the 30-day follow up! Give the participant or their family member the date to return and the telephone number of the Field Work Supervisor. Inform the participant that transport costs to come back to the clinic will be reimbursed for themselves and for a person accompanying them when they come back to give the sample.

UFOS CASE REPORT FORM

STUDY PARTICIPANT IDENTIFICATION NUMBER:
[__][__][__] - [__][__][__] - [__][__][__]

ROUTINE TREATMENT RECORD: COMPLETE THIS PAGE AT DISCHARGE OR DEATH

8. MEDICATION: While hospitalised or at discharge, were any of the following administered? If YES what was given and for how many days?	
Antibiotics? YES NO Unknown Name of medication: # of days:	**Anti-malarials?** YES NO Unknown Name of medication: # of days:
Anti-virals? YES NO Unknown Name of medication: # of days:	**NSAIDs?** YES NO Unknown Name of medication: # of days:
Blood or platelet transfusion? *(specify which)* YES NO Unknown	**Other medication** *(specify)*

9. ROUTINE INFECTION TESTING:
Have any of the following tests been done during the patient's admission?

Pathogen	Date of sample *(DD/MM/YYYY)*	Lab ID Number	Sample Type	Method	Result
Malaria			☐ Blood	☐ RDT ☐ Microscopy	☐Positive ☐Negative ☐Unknown
Crimean Congo Haemorrhagic Fever Virus			☐ Blood ☐ Other, *specify:*	☐ PCR ☐ IgM ☐IgG ☐ Other_____	☐Positive ☐Negative ☐Unknown
Dengue			☐ Blood ☐ Other, *specify:*	☐ PCR ☐ IgM ☐ IgG ☐ Other_____	☐Positive ☐Negative ☐Unknown
Rift Valley Fever			☐ Blood ☐ Other, *specify::*	☐ PCR ☐ IgM ☐ IgG ☐ Other_____	☐Positive ☐Negative ☐Unknown
Yellow Fever			☐ Blood ☐ Other, *specify:?*	☐ PCR ☐ IgM ☐ IgG ☐ Other_____	☐Positive ☐Negative ☐Unknown
Ebola Virus			☐ Blood ☐ Other, *specify:*	☐ PCR ☐ IgM ☐ IgG ☐ Other_____	☐Positive ☐Negative ☐Unknown
Other (specify)					☐Positive ☐Negative ☐Unknown

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[__][__][__] - [__][__][__] - [__][__][__]

10. Additional Participant Notes Form:

Write any additional information about the patient's illness, exposures or their 'story' here, also their home address if it is different from where they developed symptoms.