World Health Organization

T0 - Initial Case Investigation Form – page 1

Date*: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Organization/institution*: _____

Country*:_____ Interviewer: _____

Section 1: Patient information

Name*: _____ Identification #*: [__][__][__][__][__][__][__]
Telephone number: _____
Birth date*: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Sex at birth*: □ Male □ Female
or estimated age*: [___][___][___] in years or [___][___] in months or [___][___] in days
Occupation: _____
If working in a health facility, specify name and locality: _____
Residential street address*: _____
Admin Level 1* (province): _____ Admin Level 2* (district): _____
Admin Level 3* (commune): _____ Admin Level 4* (ward, parish): _____
GPS residence latitude: _____ GPS residence longitude: _____

Section 2: Clinical information

Patient clinical course

Date of onset of first symptoms*: [_D_][_D_]/[_M_][_M_]
For this episode, date first presented to health facility: [_D_][_D_]/[_M_][_M_]
Currently admitted in health facility*?: □ No □ Yes, name: _____
Outcome of illness* (circle): still sick / cured / sequelae / defaulter / death
Date of recovery, default or death*: [_D_][_D_]/[_M_][_M_]

Patient symptoms at presentation (check all reported symptoms):

□ History of fever / chills	□ Sore throat	□ Nausea/vomiting
□ General weakness	□ Non-productive cough	□ Pain □ *Muscular* □ *Chest*
□ Malaise	□ Productive cough	□ *Abdominal* □ *Joint*
□ Irritability/Confusion	□ Loss of appetite	□ Photophobia
□ Headache	□ Diarrhoea	

□ Other, specify _____

Patient signs at presentation (check all observed signs):

□ Pharyngeal exudate	□ Palpable spleen	□ Seizure
□ Conjunctival injection	□ Skin rash	□ Coma
□ Oedema of face/neck	□ Jaundice	□ Neck stiffness
□ Sunken eyes / skin pinch	□ Enlarged lymph nodes, site(s): _____	□ Bleeding, from: □ *Mouth* □ *Vagina* □ *Rectum* □ *Sputum* □ *Urine* □ *Other:* _____
□ Tender abdomen	□ Oedema of lower extremities	
□ Palpable liver		

□ Other, specify: _____

Heart rate (beats per min): [___][___][___] Blood Pressure (mmHg): [___][___][___] systolic [___][___][___] diastolic
Respiratory rate (per min): [___][___][___] O^2 saturation at room air: [___][___]%
Temperature: [___][___][___] □°C / □ F Capillary refill time> 3 sec: □ No □ Yes
MUAC: [__][__][__]mm

* indicates an EPI CORE VARIABLE for outbreak investigation

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Underlying conditions and comorbidity: (check all that apply)

□ Pregnancy □ Post-partum (< 6 weeks), delivery date: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
□ Malnutrition □ Immunodeficiency
□ Associated acute or chronic disease, specify: _____
□ Other, specify: _____

Section 3: Exposure and travel information 3 WEEKS PRIOR TO FIRST SYMPTOM ONSET

Do you **know anyone** presenting similar illness or symptoms*?: □ No □ Yes, specify:

Date of last contact, if any:	Relationship:	Place of interaction:
Date: [_D_][_D_]/[_M_][_M_]	_____	_____
Date: [_D_][_D_]/[_M_][_M_]	_____	_____

Did you participate in any **mass gatherings events?:** □ No □ Yes, specify:
Date: [_D_][_D_]/[_M_][_M_] Location: _____ Event type: _____
Date: [_D_][_D_]/[_M_][_M_] Location: _____ Event type: _____

Did you **travel** outside your residential area*?: □ No □ Yes, specify:
Date: [_D_][_D_]/[_M_][_M_] Location/place: _____
Date: [_D_][_D_]/[_M_][_M_] Location/place: _____

Did you receive care from □ **a traditional healer** and/or any other **treatment?:** □ No □ Yes, specify:
_____

Did you have any direct contact with **sick or dead animals?:** □ No □ Yes, specify:
_____

Do you have any additional information regarding **animals** or **insects** around you?: □ No □ Yes, specify:
_____

Do you suspect **food or beverage** to be the cause of the disease or symptoms?: □ No □ Yes, specify:
_____

Any other **observations to share** (e.g. contact with toxics, fake drugs, environmental exposure, ...)?: □ No □ Yes, specify
_____

Section 4: Laboratory Information

Name of testing laboratory: _____ Location: _____

Did the patient receive **antibiotics** prior to specimen collection?: □ Yes □ No □ Unknown

Sample ID	Collection date	Test performed	Result and pathogen identified

Proteinuria: □ Yes □ No □ NA	CRP: _____	Total Bilirubin: _____
Haematuria: □ Yes □ No □ NA	Potassium: _____	Creatinine: _____
Haemoglobin: _____	ALT/SGPT: _____	Urea: _____
WBC count: _____	AST/SGOT: _____	Creatine kinase (CPK): _____
Platelets: _____	Lactate: _____	Other: _____

Suspected disease(s): _____

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For questions, comments or clarifications please contact us at:
OutbreakToolkit@who.int

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