Date\* of the day: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_] Organization/institution\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interviewer name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Function / title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 1: Patient information**

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| **INTERVIEW** | | Case ID number\*: [\_\_\_][\_\_\_][\_\_\_][\_\_\_][\_\_\_][\_\_\_][\_\_\_] | |
| Date case first reported\*: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_] |  |
| Case reported by: □ Mobile Team □ Health Center / post □ Hospital □ Other □ Unknown | |
| Name of reporting facility\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| If not the case, relation of person interviewed to the case: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| I**DENTIFICATION** | Full name of patient\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If child, first and last name of the father/mother/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Birth date\*: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_] or estimated age\*: [\_Y\_][\_Y\_] □ in years or □ in months or □ in days  Sex at birth\*: □ Male □ Female  Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Residential status: Resident / refugee / displaced (circle the right option)  Living in: camp / settlement / rural / urban (circle the right option)  Residential/street address\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Landmarks to locate the house: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Village/town/city\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Admin Level 1\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admin Level 2\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Admin Level 3\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admin Level 4\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Residence GPS latitude: \_\_\_\_ . \_\_\_\_\_\_\_\_\_\_ Residence GPS longitude: \_\_\_\_\_.\_\_\_\_\_\_\_\_\_\_ | | |
| **OCCUPATION** | Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If working in a health facility, specify name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If working in health facility, specify function/position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List routine activities (outside working hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Interviewer name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Function / title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of medical evaluation: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

**Section 2: Clinical information**

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| **COURSE OF DISEASE** | 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 outcome was evaluated: [\_D\_][\_D\_]/[\_M\_][\_M\_] | | | | |
| Date\* of default, recovery or death: [\_D\_][\_D\_]/[\_M\_][\_M\_] | | | | |
| Sequelae after recovery: | □ No | □ Yes specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| More on course of disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **GENERAL** | Onset of disease: | □ Acute | □ Progressive | | |
| History of fever (>38°C): | □ Yes | □ No | □ Unknown | |
| Temperature: | [\_\_\_][\_\_\_][\_\_\_] | □°C | □°F | |
| Chills: | □ Yes | □ No | □ Unknown | |
| Profuse sweating: | □ Yes | □ No | □ Unknown | |
| Intense pain: | □ Yes | □ No | □ Unknown | |
| Sites of pain: | *□ Head □ Muscular □ Chest □ Abdominal □ Joint*  *□ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | |
| Observed abnormal bleeding: | □ Yes | □ No | | |
| Site(s) of abnormal bleeding: | □ At injection sites □ Nose □ Mouth □ Urine □ Stool □ Vagina  □ Other site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Dehydration (thirst, sunken eyes, skinfold): | □ Yes | □ No | | □ Unknown |
| Signs of shock: | □ Yes | □ No | | □ Unknown |
| Intense fatigue or weakness: | □ Yes | □ No | | □ Unknown |
| Height: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Weight: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other signs and symptoms, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Main complaints expressed by the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| **CARDIOLOGY** | Heart rate: | \_\_\_\_\_\_\_\_\_ beats per minute | | | | | | |
| Capillary refill time > 3 seconds: | □ Yes | | | □ No | | | □ Unknown | | |
| Systolic blood pressure: | \_\_\_\_\_\_\_\_\_ mm Hg | | |  | | |  | | |
| Diastolic blood pressure: | \_\_\_\_\_\_\_\_\_ mm Hg | | |  | | |  | | |
| **Observed cardiac disorders\*\*:** | **□ Yes** | | | **□ No** | | |  | | |
| Weak pulse: | □ Yes | | | □ No | | | □ Unknown | | |
| Signs of cardiac failure: | □ Yes | | | □ No | | | □ Unknown | | |
| Abnormal cardiac auscultation:  (murmur, irregular heartbeat, gallop,…) | □ Yes | | | □ No | | | □ Unknown | | |
| Peripheral oedemas: | □ Yes | | | □ No | | | □ Unknown | | |
| Other cardiac signs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **RESPIRATORY** | Respiratory rate (per min): | | \_\_\_\_\_\_\_\_\_\_\_ |  | |  | | | | |
| O2 saturation room air (%): | | \_\_\_\_\_\_\_\_\_\_\_ |  | |  | | | | |
| **Observed respiratory disorders\*\*:** | | **□ Yes** | | **□ No** | |  | | |
| Cough: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Expectoration: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Expectoration with blood: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Shortness of breath: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Respiratory distress: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Cyanosis: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Abnormal lung auscultation: crackles, murmur,… | | □ Yes | | □ No | | | □ Unknown | | | | |
| Signs of pneumonia: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Signs of pneumothorax: | | □ Yes | | □ No | | | □ Unknown | | | | |
| Other respiratory signs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |

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| **GASTOINTESTINAL** | Nausea/vomiting: | □ Yes | □ No | | □ Unknown | |
| Loss of appetite: | □ Yes | □ No | | □ Unknown | |
| **Observed gastro intestinal disorders\*\*:** | □ Yes | □ No | | □ Unknown | |
| Stomach/abdominal pain: | □ Yes | □ No | | □ Unknown | |
| Hiccups: | □ Yes | □ No | | □ Unknown | |
| Tender abdomen: | □ Yes | □ No | | □ Unknown | |
| Palpable spleen: | □ Yes | □ No | | □ Unknown | |
| Abdominal mass: | □ Yes | □ No | | □ Unknown | |
| Palpable liver: | □ Yes | □ No | | □ Unknown | |
| Diarrhea (≥3 loose/liquid stools per day): | □ Yes | □ No | | □ Unknown | |
| Bloody diarrhea (dysentery): | □ Yes | □ No | | □ Unknown | |
| Passing rice water-like stools: | □ Yes | □ No | | □ Unknown | |
| Dark bloody stools: | □ Yes | □ No | | □ Unknown | |
| Pale stools: | □ Yes | □ No | | □ Unknown | |
| Jaundice: | □ Yes | □ No | | □ Unknown | |
| Other gastro intestinal signs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **NEUROLOGY** | **Observed neurological disorders\*\*:** | □ Yes | □ No |  | |
| Paralysis  Flaccid: | □ Yes  □ Yes | □ No  Spastic: | | □ Unknown  □ Yes | |
| Abnormal movements: | □ Yes | □ No | | □ Unknown | |
| Seizures: | □ Yes | □ No | | □ Unknown | |
| Mental disorder: agitation, confusion, irritability | □ Yes, | □ No | | □ Unknown | |
| Drowsiness, coma: | □ Yes | □ No | | □ Unknown | |
| Neck stiffness: | □ Yes | □ No | | □ Unknown | |
| Other neurological signs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| **CUTANEOUS** | **Observed skin disorders\*\***: | □ Yes | □ No | | □ Unknown |
| If yes, date of onset: | \_\_\_/\_\_\_/\_\_\_\_\_ |  | |  |
| Duration (days): | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |  |
| Type: □ rash □ erythematous □ vesicular-pustular □ petechial-purpuric □ maculo-papular  □other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Localization: | □ systemic □ localized, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Itching skin: | □ Yes | □ No | | □ Unknown | | | |
| Skin necrosis: | □ Yes | □ No | | □ Unknown | | | |
| Ulceration of the skin: | □ Yes | □ No | | □ Unknown | | | |
| Enlarged lymph nodes: | □ Yes | Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Photo attached?: | □ Yes | □ No | | | |
| Other cutaneous signs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **EAR, NOSE AND THROAT (ENT)** | **Observed ENT disorders\*\*:** | □ Yes | □ No | | □ Unknown | | |
| Conjunctivitis: | □ Yes | □ No | | □ Unknown | | |
| Bleeding into eyes (conjunctival injections): | □ Yes | □ No | | □ Unknown | | |
| Runny nose: | □ Yes | □ No | | □ Unknown | | |
| Ear pain: | □ Yes | □ No | | □ Unknown | | |
| Hoarseness of voice: | □ Yes | □ No | | □ Unknown | | |
| Difficulty swallowing: | □ Yes | □ No | | □ Unknown | | |
| Sore throat: | □ Yes | □ No | | □ Unknown | | |
| Oral ulcerations: | □ Yes | □ No | | □ Unknown | | |
| Hypersalivation: | □ Yes | □ No | □ Unknown | | | | |
| Other ENT signs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |

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| **URO-GYNECOLOGY** | Recent spontaneous abortion: | □ Yes | □ No | □ Unknown |
| **Observed uro-gynecological disorders\*\*** | □ Yes | □ No | □ Unknown |
| Vaginal bleeding outside of menstruation: | □ Yes | □ No | □ Unknown |
| Vaginal discharge: | □ Yes | □ No | □ Unknown |
| Dark urine: | □ Yes | □ No | □ Unknown |
| Pain when passing urine: | □ Yes | □ No | □ Unknown |
| Not passing urine in the last 12 hours: | □ Yes | □ No | □ Unknown |
| Any other uro-gynecological signs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **UNDERLYING CONDITIONS** | Pregnancy: | □ Yes  months?\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Unknown |
| Post-partum: | □Yes  weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Unknown |
| **Underlying conditions\*\***: | □ Yes | □ No | □ Unknown |
| Chronic disease: | □ Yes | □ No | □ Unknown |
| specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Associated acute disease: | □ Yes | □ No | □ Unknown |
| specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Immunodeficiency: | □ Yes | □ No | □ Unknown |
| specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Malnutrition: | □ Yes | □ No | □ Unknown |
| MUAC measurement (children only) | \_\_\_\_\_\_\_\_\_\_\_mm |  |  |
| Any other condition impacting health, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **TREATMENTS** | **Did the patient receive any (including traditional) treatment for this episode\*\*:** □ Yes □ No □ Unknown | | | | |
|  | **Treatments** received by the patient for this episode prior to admission: □ Yes, specify in table below □ No   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Type / Name | Daily dose | Route | Start date | End date | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] |   **Treatments** received by the patient for this episode during admission: □ Yes, specify in table below □ No | | | |
|  | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Type / Name | Daily dose | Route | Start date | End date | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] | |  |  | □ IV □ IM □ Oral | [\_D\_][\_D\_]/[\_M\_][\_M\_] | [\_D\_][\_D\_]/[\_M\_][\_M\_] | | | | |
|  | Traditional treatment received?  specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes | □ No | □ Unknown |
|  | Did the treatment improve the patient medical state? | □ Yes | □ No | □ Unknown |
|  | At any time during hospitalization, did the patient receive **blood transfusion?** | □ Yes | □ No |  |
|  | Other information regarding treatment history?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **VACCINATION** | Did the patient receive full **vaccination course** according to the national immunization schedule? | □ Yes | □ No | □ Unknown /   Not applicable |
| Date of last dose received:  For which disease?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_] | | | |
| Vaccination information obtained via? □ Vaccination Card □ Health services □ Parents or another adult  Copy of vaccination card attached: □ Yes □ No | | | | |

**Interviewer name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Function / title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Section 3: Exposure and travel information THREE WEEKS PRIOR TO SYMPTOMS** | | | | | | |
| **1. CONTACTS** | How many **persons live in the same household** as the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Any **household member** presenting similar illness  or symptoms?**\*\*** | | □ Yes | □ No | □ Unknown | |
| |  |  |  | | --- | --- | --- | | Date of onset | Name and date of birth | Relationship | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Anyone **outside the household** with similar illness or symptoms?**\*\*** | | □ Yes | □ No | | □ Unknown |
| Date of onset | Name and relationship | | | | Place of interaction |
| [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **2. MASS GATHERING** | Did the patient participate in **mass gathering events\*\***? | | □ Yes | □ No | | □ Unknown |
| |  |  |  | | --- | --- | --- | | Event date | Location | Type, how many people attended? | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| **3. TRAVEL HISTORY** | Did the patient **travel** (last 3 weeks), outside her/his residential area**\*\***? | □Yes | □ No | □ Unknown | |
| |  |  |  | | --- | --- | --- | | Travel dates | Indicate from where to where | Type of transport used? | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | [\_D\_][\_D\_]/[\_M\_][\_M\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **4. NOSOCOMIAL** | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Did the patient receive **health care** (last 3 weeks)**\*\***?: | □ Yes | □ No | | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Where  Name of the facility: | □ at home □ at health facility □ at traditional clinic  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Type of care:  Invasive care (crossing skin barrier):  Dental care:  Delivery or abortion:  Admission in health care facility:  Blood transfusion: | □ Yes  □ Yes  □ Yes  □ Yes  □ Yes | Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date admitted: \_\_\_\_\_\_\_\_\_Exit date: \_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Did the patient visit a health facility without getting health care (visit a patient or any other reason)?: | □ Yes | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Did the patient use or inject illicit drugs?: | □ Yes | □ No | Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Did the patient come in contact with syringes or needles at his/her workplace?: | □ Yes | □ No | Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Did the patient donate blood or plasma?: | □ Yes | How many times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| **5. ANIMAL EXPOSUIRE** | Did the patient come into close **proximity with  any animal** prior to symptom onset**\*\***? | | □Yes | □ No | | □ Unknown |
| Specify contact: □ Trading | □ Butchering | □ Handling □ Consumption of animal products | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Animal type |  | | Was the animal dead, sick, had miscarriage or abortion? ? | | | |  | □ Domestic | □ Wild | □ Yes | □ No | □ Unknown | |  | □ Domestic | □ Wild | □ Yes | □ No | □ Unknown | |  | □ Domestic | □ Wild | □ Yes | □ No | □ Unknown | |  | □ Domestic | □ Wild | □ Yes | □ No | □ Unknown | | | | | | |
| Any other information regarding animal health events near the patient?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **6. INSECT EXPOSURE** | Did the patient get stung/bitten by any **insect, beetle, tick or other**? | | □ No | | □ Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Did the patient notice an increase in **of the number of insects, ticks, beetles or others**? | | □ No | | □ Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Did the patient notice any **newly observed insects, ticks, beetles or other** lately? | | □ No | | □ Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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|  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Sources of drinking water | Characteristic of drinking water | | | | Source of  non-drinking water | | Clear | Filtered | Treated water | Comments | |  | □ Yes □ No | □ Yes □ No | □ Yes □ No |  |  | |  | □ Yes □ No | □ Yes □ No | □ Yes □ No |  |  | |  | □ Yes □ No | □ Yes □ No | □ Yes □ No |  |  | |
| Other additional information regarding water source or use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **7. WATER AND FOOD** | |  |  |  | | --- | --- | --- | | **Food** | Sources of food | Type of food | | Morning |  |  | | Mid-day |  |  | | Evening |  |  |  |  |  |  | | --- | --- | --- | | **Drink** | Sources of beverage | Type of beverage | | Morning |  |  | | Mid-day |  |  | | Evening |  |  |   Have you attended an **event**  (e.g. festival, wedding, etc.) where food was served and you know of others who are also sick? □ No □ Yes, specify  specify common foods consumed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (please specify details about the event in part 2)  Have you shared a **meal** with others who you know are also experiencing the same symptoms?  □ No □ Yes, specify  specific foods consumed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  specify when the meals were shared: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the patient suspect a specific food or the beverage to be the cause of the disease?: □ No □ Yes, please explain why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Were there any notable changes to the types of sources of food or drinks normally consumed prior to symptom onset?: □ No □ Yes, please specify  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any other observation to share regarding food and drinks?  *(e.g. , risk of food or water contamination stored in re-used containers previously used as chemical containers, food not stored at appropriate temperatures, etc.)*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **8. CHEMICAL** | Is a **chemical exposure** suspected as the source of the outbreak? □ No □ Yes,  specify suspected product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  potential source of exposure?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  place of the chemical source?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  duration of potential exposure?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     |  |  |  |  | | --- | --- | --- | --- | | Relationship with patient | Occupation | Place of work | Suspected chemical exposure | | 1. |  |  |  | | 2. |  |  |  | | 3. |  |  |  | | 4. |  |  |  |   List the occupation of adult household members in table below: |
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| **9. PERSONAL ASSUMPTION** | Any **additional information** to share?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What (and why?) does the patient think might be the **source of this disease or facilitating its spread**?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| |  | | --- | | For how long does the patient think this event has been going on in the community? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the patient know about any similar outbreak or event that happened previously?  □ No □ Yes, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Section 4: Laboratory information**

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| **LABORATORY** | Laboratory ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Laboratory name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Town (or address) of the laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did the patient received an antibiotic prior to the collection of specimen?  Yes  No  Unknown   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Sample ID | Type of specimen  *(blood, stool, CSF,  skin smear, …)* | Collection date / date of test performed | Test performed | Pathogen  identified | |  |  | [\_D\_][\_D\_]/[\_M\_][\_M\_] /[\_D\_][\_D\_]/[\_M\_][\_M\_] |  |  | |  |  | [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_]/[\_M\_][\_M\_] |  |  | |  |  | [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_]/[\_M\_][\_M\_] |  |  | |  |  | [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_]/[\_M\_][\_M\_] |  |  | |
|  |
| **Blood formula, biochemistry, enzymes test:**    Blood gases\*\* □ Yes □ No  Arterial blood pH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bicarbonates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Partial pressure of oxygen): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Partial pressure of carbon dioxide: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Oxygen saturation: .\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other test performed and results (even if negative results): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Lab conclusion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Environmental samples taken\*\*: □ Yes □ No  Products: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of collection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Animal samples taken\*\*: □ Yes □ No  Products: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of collection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 5: Conclusion**

List here the diseases you suspected ordered from most to less likely:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Agent or disease suspected | Possible co-factors | Evidence for | Rank of certainty (over/10) | Confirmation action to be taken |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |