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

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

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

 **Section 1: Patient information**

|  |  |
| --- | --- |
| **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: | □ Yesmonths?\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Unknown |
| Post-partum: | □Yesweeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ 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 adultCopy 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\_] | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **4. NOSOCOMIAL**  |

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| --- | --- | --- | --- |
| Did the patient receive **health care** (last 3 weeks)**\*\***?:  | □ Yes | □ No | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| WhereName 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, specifyspecify 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, specifyspecific 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:  |
|  |

|  |  |
| --- | --- |
| **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**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|

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| --- |
| 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 □ NoProducts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |