World Health Organization

I. CASE IDENTIFICATION/ DEMOGRAPHIC DETAILS

Patient Name: _____	Hospital Name: _____	District: _____
EPI ID:		
☐ Male ☐ Female	Patient occupation ☐ Healthcare worker. Please specify: _____ ☐ Non-Healthcare worker. Please specify: _____	
Date of birth: (dd/ mm/ yyyy) ____ /____ /_____	If date of birth unavailable, please indicate age in month or years (*mark an X by one*): Age: _____ ☐ Years ☐ Months	
Date of admission: (dd/mm/yyyy) ____ /____ /_____	Was patient transferred from another facility? ☐ Yes ☐ No ☐ Unknown. If yes, name of facility _____	

II. VITALS AT TRIAGE:

Heart rate (bpm): _____	Respiratory Rate (rr/min): _____	Temperature (°C): _____
BP (mmHg): _____ (systolic) _____ (diastolic)	O_2 saturation room air (%):_____	Mental status: GCS_____
Capillary refill > 3 sec? ☐ Yes ☐ No	Weight (kg): _____ Self-reported height (cm): _____	Mid-upper arm circumference (MUAC) (cm) _____

III. CLINICAL DETAILS (on admission)

Date onset first symptoms (dd/mm/yyyy): ____ /____ /_____	If female patient, is she pregnant? ☐ Yes ☐ No ☐ ND
Date of admission to isolation unit (dd/mm/yyyy): ____ /____ /_____	Admitted to what type of bed? ☐ Ward ☐ ICU

Comorbid conditions

Tuberculosis	☐ Yes ☐ No ☐ Unknown		Malignancy/Chemotherapy	☐ Yes ☐ No ☐ Unknown	
Asplenia	☐ Yes ☐ No ☐ Unknown		Chronic heart failure including congenital disease	☐ Yes ☐ No ☐ Unknown	
Hepatitis	☐ Yes ☐ No ☐ Unknown		Chronic pulmonary disease	☐ Yes ☐ No ☐ Unknown	
Diabetes	☐ Yes ☐ No ☐ Unknown		Chronic kidney disease	☐ Yes ☐ No ☐ Unknown	
HIV	☐ Yes ☐ No ☐ Unknown		Chronic neurologic condition	☐ Yes ☐ No ☐ Unknown	
If yes, on ART?	☐ Yes ☐ No ☐ Unknown		Other, specify _____		
Chronic liver disease	☐ Yes ☐ No ☐ Unknown				

Symptoms (on presentation)

Fever	☐ Yes ☐ No ☐ Unknown		Headache	☐ Yes ☐ No ☐ Unknown	
Fatigue	☐ Yes ☐ No ☐ Unknown		Chest pain	☐ Yes ☐ No ☐ Unknown	
Weakness	☐ Yes ☐ No ☐ Unknown		Body pain	☐ Yes ☐ No ☐ Unknown	
Malaise	☐ Yes ☐ No ☐ Unknown		Joint Pain	☐ Yes ☐ No ☐ Unknown	
Myalgia	☐ Yes ☐ No ☐ Unknown		Hiccups	☐ Yes ☐ No ☐ Unknown	
Anorexia (i.e. loss of appetite)	☐ Yes ☐ No ☐ Unknown		Cough If cough, productive of sputum?	☐ Yes ☐ No ☐ Unknown ☐ Yes ☐ No ☐ Unknown	
Sore throat	☐ Yes ☐ No ☐Unknown				

Difficulty breathing	☐ Yes ☐ No ☐ Unknown		Abdominal pain	☐ Yes ☐ No ☐ Unknown	
Difficulty swallowing	☐ Yes ☐ No ☐ Unknown		Diarrhoea	☐ Yes ☐ No ☐ Unknown	
Nausea	☐ Yes ☐ No ☐ Unknown		Vomiting	☐ Yes ☐ No ☐ Unknown	
Irritability / Confusion	☐ Yes ☐ No ☐ Unknown				

Signs (on presentation)

Pharyngeal erythema	☐ Yes ☐ No ☐ Unknown		Enlarged lymph nodes	☐ Yes ☐ No ☐ Unknown	
Pharyngeal exudate	☐ Yes ☐ No ☐ Unknown		Lower extremity oedema	☐ Yes ☐ No ☐ Unknown	
Conjunctival injection/bleeding	☐ Yes ☐ No ☐ Unknown		Bleeding	☐ Yes ☐ No ☐ Unknown	
Oedema of face/neck	☐ Yes ☐ No ☐ Unknown		If yes, site of bleeding: _____		
Tender abdomen	☐ Yes ☐ No ☐ Unknown		Nose	☐ Yes ☐ No ☐ Unknown	
Sunken eyes or fontanelle	☐ Yes ☐ No ☐ Unknown		Mouth	☐ Yes ☐ No ☐ Unknown	
Tenting on skin pinch	☐ Yes ☐ No ☐ Unknown		Vagina	☐ Yes ☐ No ☐ Unknown	
Palpable liver	☐ Yes ☐ No ☐ Unknown		Rectum	☐ Yes ☐ No ☐ Unknown	
Palpable spleen	☐ Yes ☐ No ☐ Unknown		Sputum	☐ Yes ☐ No ☐ Unknown	
Rash	☐ Yes ☐ No ☐ Unknown		Urine	☐ Yes ☐ No ☐ Unknown	
Jaundice	☐ Yes ☐ No ☐ Unknown		IV site	☐ Yes ☐ No ☐ Unknown	
			Other, specify _____		

IV. SPECIMEN COLLECTION AND RESULTS

Specimen collection done? ☐ Yes ☐ No. If yes, what samples? ☐ Blood ☐ Urine ☐ Buccal swab Other_____

Ebola testing	**Collection date** (dd/mm/yyyy)	**Result**
Ebola RDT: ☐ Yes ☐ No Specify: _____	____ /____ /_____	☐ Pos ☐ Neg ☐ indeterminate.

		GP	NP	
Ebola PCR (admission): ☐ Yes ☐ No Specify _____	____/____/_____	☐ Pos. ☐ Neg. Ct :_____	☐ Pos. ☐ Neg. Ct :_____	☐ indeterminate
Ebola PCR (Repeat 1): ☐ Yes ☐ No	____/____/_____	☐ Pos. ☐ Neg. Ct :_____	☐ Pos. ☐ Neg. Ct :_____	☐ indeterminate
Ebola PCR (Repeat 2) : ☐ Yes ☐ No	____/____/_____	☐ Pos. ☐ Neg. Ct :_____	☐ Pos. ☐ Neg. Ct :_____	☐ indeterminate
Ebola PCR (Repeat 3) : ☐ Yes ☐ No	____/____/_____	☐ Pos. ☐ Neg. Ct :_____	☐ Pos. ☐ Neg. Ct :_____	☐ indeterminate
Malaria RDT	_____/_____/_____	☐ Pos ☐ Neg ☐ indeterminate		
Blood culture	_____/_____/_____	☐ Pos ☐ Neg ☐ indeterminate		

Did patient test positive for any other infection? ☐ Yes ☐ No If Yes, specify_____

Other clinical laboratory tests done on admission (ND = not done)

Haemoglobinuria ☐ Pos ☐ Neg ☐ ND
Proteinuria ☐ Pos ☐ Neg ☐ ND
Hematuria ☐ Pos ☐ Neg ☐ ND

Blood Gas ☐ ND ☐ Arterial ☐ Venous ☐ pH_____, pCO2_____, PaO2 ___HCO3_____
Oxygen therapy at time of blood gas (L/min) _____

Laboratory tests from admission or Hospital Day 1(HD1). (ND = not done). If repeat test done, then add Yes or No.

	Admission / HD1	Repeated		Admission / HD1	Repeated
ALT/SGPT (U/L)	☐ ND _____	☐ Yes ☐ No	Glucose (mmol/L)	☐ ND _____	☐ Yes ☐ No
AST/SGO (U/L)	☐ ND _____	☐ Yes ☐ No	Lactate (mmol/L)	☐ ND _____	☐ Yes ☐ No
Creatinine (µmol/L)	☐ ND _____	☐ Yes ☐ No	Haemoglobin (g/L)	☐ ND _____	☐ Yes ☐ No
Potassium (mmol/L)	☐ ND _____	☐ Yes ☐ No	Total bilirubin (µmol/L)	☐ ND _____	☐ Yes ☐ No
Urea (mmol/L)	☐ ND _____	☐ Yes ☐ No	WBC count (x10^9/L)	☐ ND _____	☐ Yes ☐ No
Creatinine kinase (U/L)	☐ ND _____	☐ Yes ☐ No	Platelets (x10^9/L)	☐ ND _____	☐ Yes ☐ No
Calcium (mmol/L)	☐ ND _____	☐ Yes ☐ No	PT	☐ ND _____	☐ Yes ☐ No
Sodium (mmol/L)	☐ ND _____	☐ Yes ☐ No	aPTT (seconds)	☐ ND _____	☐ Yes ☐ No

V. Complications at any time (OD= onset date, format: dd/mm/yyyy)

Bleeding	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Coma (GCS < 8)	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Shock	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Bacteraemia	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Meningitis*	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Hyperglycemia	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Confusion	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Hypoglycemia	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Seizure	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Other, specify _____		OD___/____/_____

***meningitis defined either clinically or with lumbar puncture**

VI. TREATMENT INFORMATION: (please include loading dose, maintenance and switch to oral therapy)

Did patient receive ANY antimicrobial/antiviral therapy? ☐ Yes ☐ No

Type	Dose	Route	Frequency	Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
Antibacterial: ☐ Yes ☐ No Specify: _____		☐ IV ☐ oral		___/____/_____	___/____/_____
Antimalarial: ☐ Yes ☐ No Specify: _____		☐ IV ☐ oral		___/____/_____	___/____/_____
Other: Specify: _____		☐ IV ☐ oral		___/____/_____	___/____/_____

At any time during the hospitalization, did the patient receive any of the following?

Oral rehydration salts ☐ Yes ☐ No	IV fluid therapy ☐ Yes ☐ No	Access type ☐ Intra-osseous ☐ PIV ☐ CVC
Blood transfusion ☐ Yes ☐ No	Oxygen therapy ☐ Yes ☐ No	Invasive mechanical ventilation ☐ Yes ☐ No
Renal replacement therapy ☐ Yes ☐ No		Vasopressors/inotropes ☐ Yes ☐ No

VII. DISCHARGE DETAILS

Date of Discharge/transfer from health facility/death (dd/mm/yyyy): ____ /_____/_____

Final Diagnosis: ☐ Ebola virus disease ☐ Other (specify)

Outcome at discharge

☐ Full recovery withOUT sequelae at time of discharge

☐ Full recovery WITH sequelae If yes, specify: ☐ hearing loss ☐ if pregnant, spontaneous abortion ☐ ocular complications ☐ extreme fatigue ☐ arthralgia ☐ neurologic complications, specify _____.☐ other: _____

☐ Dead

☐ Referred to another facility. If yes, which facility: _____

☐ Left against medical advice

☐ Survivor counselling provided.

Form completed by: _____