World Health Organization

ADMISSION FORM

I. CASE IDENTIFICATION/ DEMOGRAPHIC DETAILS

Patient Name: _____	ETU Number: _____	
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 (/min): _____	Temperature (°C): _____
BP (mmHg): _____ (systolic) _____ (diastolic)	O_2 saturation room air (%):_____	Mental status: A / V / P / U
Capillary refill > 3 sec? ☐ Yes ☐ No	Weight (kg): _____ Self-reported height (cm): _____	Mid-upper arm circumference (MUAC) (mm) _____

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 and on ART ☐ Yes and not on ART ☐ No ☐ Unknown	Chronic neurologic condition	☐ Yes ☐ No ☐ Unknown
Chronic liver disease	☐ Yes ☐ No ☐ Unknown	Other, specify _____	

Symptoms (on presentation)

Fever	☐ Yes ☐ No ☐ Unknown	Headache	☐ Yes ☐ No ☐ Unknown	Chest pain	☐ Yes ☐ No ☐ Unknown
Fatigue	☐ Yes ☐ No ☐ Unknown	Nausea	☐ Yes ☐ No ☐ Unknown	Difficulty breathing	☐ Yes ☐ No ☐ Unknown
Weakness	☐ Yes ☐No ☐ Unknown	Chest pain	☐ Yes ☐ No ☐ Unknown	Difficulty swallowing	☐ Yes ☐ No ☐ Unknown
Malaise	☐ Yes ☐ No ☐ Unknown	Joint Pain	☐ Yes ☐ No ☐ Unknown	Abdominal pain	☐ Yes ☐ No ☐ Unknown
Myalgia	☐ Yes ☐ No ☐ Unknown	Hiccups	☐ Yes ☐No ☐ Unknown	Diarrhoea	☐ Yes ☐ No ☐ Unknown
Anorexia (i.e. loss of appetite)	☐ Yes ☐ No ☐ Unknown	Cough	☐ Yes and productive ☐ Yes and not productive ☐ No ☐ Unknown	Vomiting	☐ Yes ☐ No ☐ Unknown
Sore throat	☐ 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	☐ No ☐ Unknown
Oedema of face/neck	☐ Yes ☐ No ☐ Unknown		☐ Nose
Tender abdomen	☐ Yes ☐ No ☐ Unknown		☐ Mouth
Sunken eyes or fontanelle	☐ Yes ☐ No ☐ Unknown		☐ Vagina
Tenting on skin pinch	☐ Yes ☐ No ☐ Unknown		☐ Rectum
Palpable liver	☐ Yes ☐ No ☐ Unknown		☐ Sputum
Palpable spleen	☐ Yes ☐ No ☐ Unknown		☐ Urine
Rash	☐ Yes ☐ No ☐ Unknown		☐ IV site
Jaundice	☐ Yes ☐ No ☐ Unknown		☐ Other, specify _____

IV. SPECIMEN COLLECTION AND RESULTS

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

Ebola testing	**Collection date** (dd/mm/yyyy)	**Result**		
Ebola RDT: ☐ Not done ☐ Oraquick ☐ Others: _____	____ /____ /_____	☐ Pos ☐ Neg ☐ indeterminate.		
Ebola PCR (admission): ☐ Not done ☐ GeneXpert ☐ Others: _____	____ /____ /_____	**GP** ☐ Pos. ☐ Neg. Ct :_____	**NP** ☐ 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
Results: pH_____, pCO2_____, PaO2 ___HCO3_____
Oxygen therapy at time of blood gas (L/min) _____

Laboratory tests on admission or Hospital Day 1(HD1). (ND = not done)

Biochemistry	Values	Not Done	**CBC & Clotting panel**	Values	Not Done
ALT/SGPT (U/L)		☐ ND	Glucose (mmol/L)		☐ ND
AST/SGO (U/L)		☐ ND	Lactate (mmol/L)		☐ ND
Creatinine (µmol/L)		☐ ND	Haemoglobin (g/L)		☐ ND
Potassium (mmol/L)		☐ ND	Total bilirubin (µmol/L)		☐ ND
Urea (mmol/L)		☐ ND	WBC count (x10^9/L)		☐ ND
Creatinine kinase (U/L)		☐ ND	Platelets (x10^9/L)		☐ ND
Calcium (mmol/L)		☐ ND	PT		☐ ND
Sodium (mmol/L)		☐ ND	aPTT (seconds)		☐ ND

V. Complications on admission

Bleeding ☐ Yes ☐ No ☐ Unknown	Coma (P/U in AVPU scoring) ☐ Yes ☐ No ☐ Unknown
Shock ☐ Yes ☐ No ☐ Unknown	Bacteraemia ☐ Yes ☐ No ☐ Unknown
Meningitis* ☐ Yes ☐ No ☐ Unknown	Hyperglycemia ☐ Yes ☐ No ☐ Unknown
Confusion ☐ Yes ☐ No ☐ Unknown	Hypoglycemia ☐ Yes ☐ No ☐ Unknown
Seizure ☐ Yes ☐ No ☐ Unknown	Other, specify _____

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

VI. TREATMENT INFORMATION ON ADMISSION: (please indicate units)

Type	**Dose**	**Route**	**Frequency**
Antibacterial: ☐ Yes ☐ No Specify: ☐ amoxicillin ☐ ceftriaxone ☐ cefixime ☐ other_____		☐ IV ☐ oral	
Antimalarial: ☐ Yes ☐ No			
Select all that applies: ☐ Artesunate		☐ IV	
☐ Arthemeter		☐ IM	
☐ Arthemeter/Lumefantrine	/	☐ oral	
☐ Artesunate/Amodiaquine	/	☐ oral	
Other: Specify: _____		☐ IV ☐oral	

Ebola experimental treatment: ☐ Yes ☐ No	Indicate if yes: ☐ZMapp. ☐ Remdesivir (GS-5734). ☐ REGN3470-3471-3479. ☐ Favipiravir ☐ mAb114

At the time of admission, did the patient receive any of the following?

Oral/orogastric fluids? ☐ Yes ☐ No ☐ Unknown. To specify: ☐ ORS :_____ml ☐ Water: _____ml ☐ Others:_____& Vol____ml	IV fluid therapy ☐ Yes ☐ No ☐ Unknown If yes, specify: _____ml using ☐ Ringer's lactate ☐ Normal Saline ☐ Others, specify _____	Access type ☐ Intra-osseous ☐ PIV ☐ CVC ☐ Unknown
Blood transfusion ☐ Yes ☐ No ☐ Unknown	Oxygen therapy ☐ Yes ☐ No ☐ Unknown If yes, specify: _____L/min with ☐Nasal cannula ☐ Face mask ☐face mask with reservoir bag	Vasopressors/inotropes ☐ Yes ☐ No ☐ Unknown
Renal replacement therapy ☐ Yes ☐ No ☐ Unknown	Invasive mechanical ventilation ☐ Yes ☐ No ☐ Unknown	

Form completed by: _____