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**Session C3 Annexes**

**Session C3 – Annex 1: Initial case investigation form**

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| WHO-EN-C-H **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\_]  or estimated age\*: [\_\_\_][\_\_\_][\_\_\_] in years or [\_\_\_][\_\_\_] in months or [\_\_\_][\_\_\_] in days  Sex at birth\*: □ Male □ Female  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  □ General weakness  □ Malaise  □ Irritability/Confusion  □ Headache  □ Sore throat  □ Non-productive cough  □ Productive cough  □ Loss of appetite  □ Diarrhoea  □ Nausea/vomiting  □ Pain □ Muscular □ Chest □ Abdominal □ Joint □ Photophobia □ Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient signs at presentation (check all observed signs): □ Pharyngeal exudate □ Conjunctival injection □ Oedema of face/neck □ Sunken eyes / skin pinch □ Tender abdomen □ Palpable liver □ Palpable spleen □ Skin rash □ Jaundice □ Enlarged lymph nodes, site(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Oedema of lower extremities  □ Seizure □ Coma □ Neck stiffness □ Bleeding, from: □ Mouth □ Vagina □ Rectum □ Sputum □ Urine □  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart rate (beats per min): [\_\_\_][\_\_\_][\_\_\_] Blood Pressure (mmHg): [\_\_\_][\_\_\_][\_\_\_] systolic [\_\_\_][\_\_\_][\_\_\_] diastolic Respiratory rate (per min): [\_\_\_][\_\_\_][\_\_\_]  O2 saturation at room air: [\_\_\_][\_\_\_]% Temperature: [\_\_\_][\_\_\_][\_\_\_] □°C / □ F  Capillary refill time> 3 sec: □ No □ Yes MUAC: [\_\_][\_\_][\_\_]mm |

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| WHO-EN-C-H **T0 - Initial Case Investigation Form - page 2**  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: Date: [\_D\_][\_D\_]/[\_M\_][\_M\_]  Relationship:  Place of interaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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  Proteinuria: □ Yes □ No □  NA Haematuria: □ Yes □ No □ NA  Haemoglobin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WBC count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Platelets:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CRP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Potassium: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ALT/SGPT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  AST/SGOT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lactate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Total Bilirubin:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Creatinine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Urea: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Creatine kinase (CPK): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suspected disease(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \* indicates an EPI CORE VARIABLE for outbreak investigation  © World Health Organization 2019. All rights reserved. |

Source: WHO Outbreak Toolkit, available at: <https://www.who.int/emergencies/outbreak-toolkit/data-collection-standards/t0-initial-case-investigation-form>

**Session C3 – Annex 2: Laboratory test request form**

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| **Laboratory Test Request Form – [*name* laboratory] Date received:\_\_\_/\_\_\_/\_\_\_\_**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Patient details** | | |  | **Requester details:** | | | Name: | Laila Samy | |  | Name: |  | | Address: | 0312 Alhubu Lane, Karan Province, Salam | |  | Organization |  | | Telephone number: | +1863-9541 | |  | Address: |  | | Date of Birth: | 21 September 1988 | |  | Telephone number: |  | | Gender: |  Male | X Female |  |  |  |   **Sample details:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Urgency: | * Normal |  | Sample taken from patient: | | | * URGENT | Date: | (dd/mm/yyyy) | |  |  |  | Time: | (hh/mm) | | * Fasting | * Non-fasting |  |  | |  |  |  |  |  | | --- | --- | --- | --- | | * Blood * Faeces | * Urine * Sputum | * Swab * Fluids | * Tissue * Cytology | | * Other: |  |  |  | |  |  |  |  |   **Relevant clinical information:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Drug therapy: |  | Last dose: | |  | |  |  | Date: | (dd/mm/yyyy) | | |  | Time: | (hh/mm) | | | Other relevant clinical information: |  | | | | |  | | | | |  |  | | | |   **Examination requested:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Profile test** | | **Biochemistry** | | **Hematology** | **Microbiology** | **Anatomical Pathology** | |  G2000   G 2000-X   GT9   GTI   NEO   ES   HB3 |  DFS   LFT   RFT   TFT   MAC   LGL   LIP |  CEA   CA 1   CA 5   CA 9   PSA   AFP   Glucose |  HIV 1 & 2   HbA1c   HBsAg   H. pylori   Uric Acid   Free T4 |  FBE (incl. ESR)   FBC   Hb   TWDC   Platelets   ABO & Rh (D)   Malaria parasites |  Urine FEME   RPR (VDRL)   Microscopy/ Culture/Sensitivity   AFB (ZN) Smear Only   AFB Smear & Culture |  Histology   Non-Gynae/FNA  Site:   |  | | --- | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Additional tests:** | | | | **Cervical Cytology:** | | | | | | | | |  | | | |  Pap smear   Normal   Post-Mono Blood   Susp lesion | | | | | | | | |  | | | | |  | | | | |  | | | | |  | | | |  Other: | | | | |  | |  | |  | | | | Site |  Cervix   Vault   Other: | | | | |  Endocx   Lat. Vag. Wall. |  Post Fornix | |  | | | | |  | | | | |  | | | | LMP | | (dd/mm/yyyy) | | | | |  | |  | | | |  Post – menopausal   HRT (hormone Replacement | | | | | | | | |  | | | | |  | | | |  Other: | | |  | | | | | | |  | | | |  | | | | | | | | | **Date:(dd/mm/yyyy)** |  |  | **Requester’ssignature:** | | | | |  | | | | |