

Study # 027	CHILDID	Plate # 091	Visit # 004	F9_DATE	VERSION#
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Site	Center	Child ID	Day	Month	Year
					VERSION

1. Was the Memory Aid completed?  No  Yes  Partial **MEMORY\_AID**  
*[If "No", "X" and sign the form and hand over to supervisor.]*
2. If "Yes" or "Partial", what was the first and last day of diarrhea according to the Memory Aid?

First day of Diarrhea:   **DRH\_FIRST**

Last day of Diarrhea:   **DRH\_LAST**

*[Code 1 to 14 from Memory Aid, Column 1]*

**Notes or comments** *[Add date and initials or staff code]*

Interviewer's Name \_\_\_\_\_ **INT\_CODE**     
 Staff code

Quality Control's Name \_\_\_\_\_ **QC\_CODE**          
 Staff code Day Month Year