

STUDY ID | 3 | | | |

Patient Initials | | | |
Last FirstToday's date | | | | / | | | | / | | | |
day month year

Subject Death Record

Date and Causes of Death	
Date of Subject Death (if exact date cannot be ascertained from records and history record best approximation)	/ / day month year
Cause of death as recorded on Death Certificate or ascertained from contact report (List up to 3 diagnoses with appropriate codes)	Primary Cause of Death _____ Dx Code: _____ Other Contributing Causes _____ Dx Code: _____ Other Contributing Causes _____ Dx Code: _____ If an appropriate diagnostic code does not exist, add to list and assign next available diagnostic code number
Primary source of information for cause(s) of death (tick one only)	<input type="checkbox"/> Autopsy report <input type="checkbox"/> Health facility (when no autopsy done) <input type="checkbox"/> Family member <input type="checkbox"/> Other: If other, specify: _____

Relationship to Malaria	
Was Subject's Death related to Malaria? (tick one only)	<input type="checkbox"/> Yes <input type="checkbox"/> Possibly <input type="checkbox"/> No <input type="checkbox"/> Unknown
Place of Death	
Where did the participant die? (tick one only)	<input type="checkbox"/> Home <input type="checkbox"/> Health centre II, III, IV <input type="checkbox"/> Hospital <input type="checkbox"/> Private Clinic <input type="checkbox"/> Other: If other, specify: _____
If subject died in health facility, record date of admission	/ / day month year

*Remember to complete Hospitalization Form if hospitalized.

Completed by | | | | (initials)