STUDY ID |___|___|___| **Patient Initials** |___|___| ***Last First*** **Today'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)*	|__| Autopsy report |__| Health facility (when no autopsy done) |__| Family member |__| Other: If other, specify: _____

Relationship to Malaria	
Was Subject's Death related to Malaria? *(tick one only)*	|__| Yes |__| Possibly |__| No |__| Unknown
Place of Death	
Where did the participant die? *(tick one only)*	|__| Home |__| Health centre II, III, IV |__| Hospital |__| Private Clinic |__| 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)