MINISTRY OF HEALTH KENYA

MOH 502

Integrated Case Based Surveillance form

NB. '**Use this form for a single case only**'

"To be completed at the National Level'

EPID Number: …. ….. ……. …… ……..
Country Province District Year

Date form received at Central Level ____/_____/_____

A. Name of Site Reporting & Disease being reported

1. Health Facility …… 2. Division ……

3. District …… 4. Province ……

5. Disease reported (Tick One)

☐ AFP ☐ Neonatal Tetanus ☐ Measles ☐ Meningitis ☐ Plague ☐ Viral Hemorrhagic Fever ☐ Yellow Fever ☐ S. Avian Influenza ☐ Other specify) ……..

NB: If you suspect AI, Please fill the Avian Influenza Case Investigation form.

B. Identification

6. Name of patient ……

7. Sex 1 = Male 8. Age: ☐ ☐ ☐ 9. D.o.B. __/___/_
2 = Female ☐ Year Month Day

10. Parent/Guardian: ……

11. Immediate Contact: ……

a. Patient's residence ……
b. Neighbourhood (major landmark): ……
c. Street/Plot/House Number:……
d. Town/City: ……
e. District: …… f. Province: ……

12. Date first seen at health facility: _____/_____/_____

13. IP/OP No. ……

14. Date Health facility notified District level: ____/_____/_____
Vaccination History [For disease under investigation) cases of Measles, AFP (exclude birth dose of OPV) NT(TT in mother) Yellow fever, Meningitis and suspected Avian Influenza]

15. Was the patient vaccinated against illness? ☐ 1 = Yes 2=No
9= unknown. If yes, no of doses ……

16. Any vaccination given in the last two months? ☐ 1= Yes
2= No 9= unknown. Date of vaccination ____/___/___N/A

C. I Clinical Information

17. Date of onset of illness ____/_____/_____

18. Hospitalised: ☐ 1=Yes, 2= No Date of Admission __/___/__

19. Status of the patient:
☐ Still hospitalised ☐ Discharged ☐ Dead

For Acute Flaccid Paralysis (AFP) Case Only

C. II Clinical History

20. Date of onset of paralysis: ____/_____/_____

21. Signs and symptoms: ☐ Fever at onset of paralysis
☐ Sudden onset of paralysis ☐ Paralysis progressed ≤ 3 days
Flaccid (floppy) 1 = Yes 2 = No

22. Site(s) of paralysis: Left Leg ☐ Right Leg ☐ Left Arm ☐
Right Arm ☐ Are both sides affected? 1 = Yes 2 = No

Follow-up Examination (to be completed by the district 60-90 days after onset of paralysis)

23. Date of follow-up examination: ____/_____/_____

24. Site(s) of paralysis:
Left Leg ☐ Right Leg ☐ Left Arm ☐ Right Arm ☐ 1 = Yes 2 = No

25. Findings at follow-up ☐
1 = Residual paralysis 2= No residual paralysis
3= Lost to follow-up 4=Death before follow-up

Name &Designation of person doing the follow-up
……

For Neonatal Tetanus Case Only

C. III Delivery Practices

26. Where was the baby delivered? ☐ 1 = Health facility
2= Home by trained attendant 3=Home by untrained attendant
9 = Unknown

27. If delivery was in health facility record the name: ……
Health facility

28. Was the cord cut with sterile/clean blade? ☐ 1 = Yes
2= No 9 = Unknown

29. How was the cord stump treated or dressed? ……

Baby's symptoms

30. How old (in days) was the baby when the symptoms began?
……. Days ……. Unknown

31. At birth, did the baby suck normally? ☐ 1 = Yes 2= No
9 = Unknown

32. After the first two days of life, was the baby unable to suck?
☐ 1 = Yes 2= No 9 = Unknown

33. Did the baby have convulsions (stiffness or fits?) ☐ 1 = Yes
2= No 9 = Unknown

34. Was the case confirmed as neonatal tetanus (if yes to last 3 questions, answer yes) ☐ = Yes 2= No 9 = Unknown

Treatment

35. Was the sick baby treated at a health facility? ☐ 1 = Yes
2= No 9 = Unknown

36. Did the mother? ☐ 1 = Yes 2= No 9 = Unknown
(If yes, complete Case Investigation Form for Maternal Deaths)

Case Response (Sensitise TBAs and community leaders on safe delivery practices and cord care. Provide booster TT doses to mother of NNT case an women of child-bearing age in local community around the case.)

37. Did a case response for the mother take place? ☐ 1 = Yes
2= No 9 = Unknown

38. Did a case response take place in her locality ☐ 1 = Yes
2= No 9 = Unknown

39. Comments ……

C. IV For Measles case only

Signs and symptoms

40. Presence of fever ☐ 1 = Yes 2= No

41. Date of onset of rash ____/_____/_____ type of rash
Maculopappular ☐ Other ☐

42. Was home of patient visited for contact investigation?
If yes, date visited ____/_____/_____

43 Is the case epidemically linked to a laboratory-confirmed case? ☐

D. Laboratory

1. Specimen collection [TO BE COMPLETED BY THE HEALTH FACILITY

If lab specimens collected, complete the following information and send a copy of this form to the lab with the specimen]

44. Was a specimen collected? Yes/No ☐ If No, why ……

45. Date(s) of specimen collection: ___/____/___ & ___/___/___

46. Specimen: Stool ☐ Blood ☐ CSF ☐ OPS ☐ NS ☐
Other ☐ If other, specify ……

47. Date specimen (s) sent to laboratory (specify lab): __/___/___

Form completed by:

Name: …… Designation: ……
Phone No. …… Date case investigation: __/__/__
Fax No. …… …… Email: ……
Signature: …… Date completed: ___/___/___

Comments: ……
……

S. AI – Suspected Avian Influenza
*OPS – Oral pharangeal Swab
*NS – Nasal Swab