PATIENT FORM

PHC NAME: _____ DATE: _____

PATIENT NAME: _____

PATIENT MODULE

Q.#	QUESTIONS	CODES	GO TO Q.
1.	Patient age (as of last birthday) *Enter 0 if less than 1 year*	☐☐	
2.	Patient gender	**Male……1** **Female ……2**	
3.	Do you have a contact GSM number?	**Yes ……1** **No ……2**	**→ 5**
4.	What is your phone number?		
5.	How did you get to this clinic today?	**Walked ……1** **Bus or shared van ……2** **Taxi ……3** **My own car/motorcycle ……4** **Boat ……5** **Other (Specify)_____6**	
6.	IF WALKED ASK: How long did it take you to walk from your house to this clinic? IF CAME BY OTHER MEANS ASK: If you *walked*, how long would it take you to walk from your house to this clinic?	**Minutes _____** **Hours _____**	

PATIENT FORM

PHC NAME: _____ DATE: _____

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Why have you visited the PHC today?

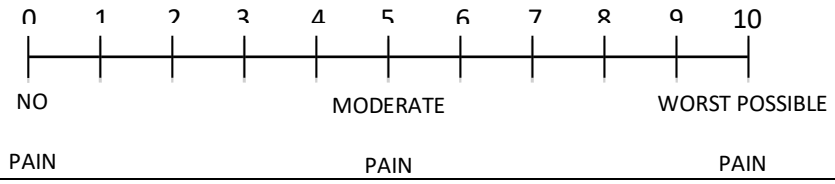
TICK THE BOX TO INDICATE THE COMPLAINT. FOR OTHER COMPAINTS, REFER TO THE CODE LIST AND ENTER THE APPROPRIATE CODE. FOR EACH COMPLAINT, ENTER THE DURATION IN THE SPACE PROVIDED

☐	Fever		☐	Ear pain/earache	
☐	Cough		☐	Ear discharge	
☐	Diarrhea		☐	Palpitations/awareness of	
☐	Chills		☐	Headache	
☐	Weakness/tiredness (general)		☐	Convulsion/seizure	
☐	Feeling Ill		☐	Shortness of breath/dyspnoea	
☐	Chest Pain		☐	Sneezing/nasal congestion	
☐	Irritable Infant		☐	Haemoptysis	
☐	Abdominal pain/cramps gen		☐	Dysuria/painful urination	
☐	Abdominal pain epigastric		☐	Urinary frequency/urgency	
☐	Nausea		☐	Antepartum bleeding	
☐	Vomiting		☐	Post-partum bleeding	
☐	Constipation		☐	Vaginal discharge	
☐	Abdominal distension		☐	Other:	
☐	Red eye		☐	Other:	
☐	Eye discharge		☐	Other:	

How would you describe the severity of symptoms experienced?

EXPLAIN THE SCALE TO THE RESPONDENT AND ASK THEM TO POINT TO WHERE THEY THINK THEY FALL ALONG THE SCALE. RECORD THE CORRESPONDING NUMBER

_____



PATIENT FORM

PHC NAME: _____ DATE: _____

PATIENT NAME: _____

Q.#	QUESTIONS	CODES	GO TO Q.
1.	How would you rate your health today?	**Excellent……1** **Very good ……2** **Good……3** **Fair ……4** **Poor ……5**	
2.	TODAY would you have any physical trouble or difficulty: Walking up a flight of stairs?	**None ……1** **Some ……2** **A lot ……3**	
3.	TODAY would you have any physical trouble or difficulty: Running the length of a football field?	**None ……1** **Some……2** **A lot……3**	
	DURING THE PAST WEEK: How much trouble have you had with:		
4.	Hurting or aching in any part of your body	**None ……1** **Some……2** **A lot……3**	
5.	Sleeping	**None ……1** **Some ……2** **A lot ……3**	

PATIENT FORM

PHC NAME: _____ DATE: _____

PATIENT NAME: _____

CLINICAL OBSERVATION MODULE

Q.#	QUESTIONS	CODES	GO TO Q.
1.	Does provider respectfully greet the patient/caretaker?	**Yes .....1** **No 2**	
2.	Does provider ask patient/caretaker the purpose of the visit?	**Yes .....1** **No 2**	
3.	What is the presenting complaint?		
	Presenting complaint		
☐	Fever		**→4**
☐	Cough		**→5**
☐	Diarrhea		**→6**
☐	Other symptom:		
☐	Other symptom:		
☐	Other symptom:		
☐	Other symptom:		

PATIENT FORM

PHC NAME: _____ DATE: _____

PATIENT NAME: _____

Indicate if the provider asked any of the following questions

4. Fever	5. Cough	6. Diarrhea
☐ The duration of fever ☐ Pattern (Periodicity) of fever ☐ Presence of chills, sweats ☐ Presence of cough ☐ Presence of sore throat / pain during swallowing ☐ Presence of vomiting ☐ Presence of diarrhea ☐ Presence of convulsions ☐ Presence of running nose ☐ Any medication given ☐ Amount of medication given ☐ Other	☐ The duration of cough ☐ Sputum production or dry cough ☐ Presence of blood in sputum / color of sputum ☐ Whether cough is aggravated by dust or smoke etc.? ☐ Whether it gets worse at night ☐ Any contact with person with chronic cough ☐ Presence of night sweats ☐ Presence of chest pain ☐ Presence of difficulty in breathing ☐ Presence of fever ☐ Appetite ☐ Presence of diarrhea ☐ Presence of vomiting ☐ General health condition (tiredness/fatigue)	☐ The duration of diarrhea ☐ Frequency of stools (how often) ☐ Consistency of stools ☐ Presence of blood in stools ☐ Presence of mucus in stools ☐ Presence of abdominal pain ☐ Presence of vomiting ☐ Presence of fever ☐ General health condition (tiredness/fatigue) ☐ Whether other family members or neighbors have diarrhea ☐ Any medications given at home
Additional questions for children under 5: ☐ Ability to drink or breastfeed ☐ Difficulty in breathing / chest pain ☐ Ear pain/discharge ☐ Pain/crying while passing urine ☐ Vaccination history	**Additional questions for children under 5:** ☐ Ability to drink or breastfeed ☐ Presence of convulsions ☐ Presence of ear problems ☐ Vaccination history	**Additional questions for children under 5:** ☐ Ability to drink or breastfeed ☐ Presence of convulsions ☐ Presence of ear problems ☐ Presence of cough or difficulty breathing ☐ Presence of tears when baby cries ☐ Whether the baby started taking other food ☐ Whether the change in food happened recently ☐ How the food has been given ☐ Who prepares and feeds the child ☐ The hand washing practice of the person who feeds the child ☐ Vaccination history

PATIENT FORM

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Record whether the provider carried out the following steps and/or examinations. Note that some of the following steps may be performed simultaneously.

General	**Chest**	**Abdomen**
☐ Feels for temperature with back of palms ☐ Takes temperature with thermometer ☐ Measures blood pressure ☐ Counts respiratory rate ☐ Checks pulse rate ☐ Checks for pallor in the palms, conjunctiva (or other signs of anemia) ☐ Checks signs of dehydration (dry tongue, buccal mucosa, delayed capillary refill, sunken eyes/fontanelle, skin pinch)	☐ Observes breathing for lower chest in-drawing (lifting shirt) ☐ Percusses chest ☐ Auscultates the chest ☐ Checks for tracheal deviation	☐ Check for abdominal tenderness and guarding ☐ Check for rigidity ☐ Palpates the abdomen for organ enlargement ☐ Percuss the abdomen ☐ Auscultate the abdomen
Head and Neck	**Upper & Lower limbs**	**For children under 5**
☐ Checks for neck stiffness ☐ Checks ear ☐ Examines throat ☐ Check for enlarged lymph nodes ☐ Examines the thyroid ☐ Takes temperature with thermometer ☐ Observes for nasal flaring	☐ Check for finger clubbing ☐ Check for peripheral cyanosis ☐ Palpate the axilla ☐ Check for the femoral region for hernias	☐ Assesses general health condition (awake/ lethargy/ tiredness/ fatigue) ☐ Checks for visible severe wasting ☐ Looks for edema of hands, feet or face ☐ Weighs the child ☐ Checks the child's weight against a growth chart ☐ Offers the child a drink of water / observes breastfeeding ☐ Checks for skin changes/rash

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Select all lab tests mentioned. If none, check the box for “no investigations”

0.	No investigations	☐
1.	Malaria test	☐
2.	HIV test	☐
3.	Full Blood Count	☐
4.	ESR	☐
5.	Hb/PCV	☐
6.	WBC	☐
7.	Urinalysis	☐
8.	Urine MCS	☐
9.	Stool analysis/Sends stool for testing of culture and parasite	☐
10.	Blood glucose	☐
11.	Sputum AFB	☐
12.	Mantoux test	☐
13.	HVS MCS/High vaginal swab	☐
14.	Lumbar puncture	☐
15.	Chest X-Ray	☐
16.	Ultrasound	☐
17.	ECG	☐
18.	EEG	☐
19.	Pregnancy test	☐
20.	Other	☐

PATIENT FORM

PHC NAME: _____ DATE: _____

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Q.#	QUESTIONS	CODES	GO TO Q.
1.	Was any diagnosis made?	**Yes .....1** **No 2**	**→Next Sec.**
2.	Were any medicines prescribed?	**Yes .....1** **No 2**	
	Name of the medicine	**Dosage prescribed**	

Select all that apply below with regards to the clinician's communication with the patient:

1.	Looks at the patient while talking	☐
2.	Tells the patient his or her diagnosis (any name)	☐
3.	Explains the diagnosis (in common language)	☐
4.	Explains the treatment being provided	☐
5.	Gives any health education related to the diagnosis?	☐
6.	Refers the patient to another facility?	☐
7.	Explains whether or not to return for further treatment	☐
8.	Listens properly to the patient/caregiver	☐
9.	Allows the patient to talk	☐