ASSESSMENT FORM – SAVE THE CHILDREN – KERRY TOWN EBOLA TREATMENT CENTRE

DATE: [___][___]/[___][___]/ 2014 (DD/MM/YYYY)	**PATIENT ID #: KT– [__] – [__][__][__][__][__]** KT-2 = Triage; KT-3 = Confirmed; KT-4 = morgue

Form completed by (write your name): _____

OBSERVATIONS

Current consciousness: ☐**A** ☐**V** ☐**P** ☐**U** **Confused/agitated:** ☐YES ☐NO

Temperature: [___][___].[___]°C

Heart Rate: [___][___][___]beats /min

Respiratory Rate: [___][___]breaths /min

Weight (kg) |___|___|.|___|

***If child under 5 years*, Mid Upper Arm Circumference (cm):** |___|___|.|___|

Systolic BP: [___][___][___]mmHg **Diastolic BP:** [___][___][___]mmHg

Capillary refill time (sec): [___] seconds ☐UNKNOWN

O_2 saturation: [___][___][___]% **On:** ☐Room air ☐Supplemental Oxygen ☐Unknown

Clinically shocked? ☐YES ☐NO ☐UNKNOWN

Additional symptoms (primary Ebola symptoms asked on Triage form)

(Ask open questions first then follow up with specific symptoms)

Nausea	☐Yes	☐No	***If BLEEDING,* specify site:**		
Backpain	☐Yes	☐No	**Nose/mouth**	☐Yes	☐No
Chest pain	☐Yes	☐No	**Cough**	☐Yes	☐No
Sore throat	☐Yes	☐No	**Vomit**	☐Yes	☐No
Decreased urine output	☐Yes	☐No	**Urine**	☐Yes	☐No
Cough	☐Yes	☐No	**Stool**	☐Yes	☐No
Seizures	☐Yes	☐No	**Vaginal** (non-menstrual)	☐Yes	☐No
Specify other symptoms:					

EXPOSURE INFORMATION

Did the patient attend a funeral in the month before becoming ill?

***If YES*: Did patient participate (carry/touch body)?** ☐ YES ☐ NO ☐ UNKNOWN

Did the patient visit a traditional healer in the month before becoming ill?

☐ YES ☐ NO ☐ UNKNOWN

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EXPOSURE INFORMATION continued

Did the patient have contact with a suspected or confirmed Ebola case in the month before becoming ill? ☐YES ☐NO ☐ UNKNOWN

If YES, *complete following section for up to the* ***2*** *most recent contacts*

Contact #1

What was Ebola status of *contact?* ☐CONFRIMED ☐ SUSPECTED ☐ UNKNOWN

Amount of time since last contact [____] ☐DAYS ☐ WEEKS

Type of contact: ☐ body fluids ☐ direct physical contact with body

☐ shared items/linens ☐ shared room/home

Is the contact alive or dead? ☐ALIVE ☐ DEAD ☐ UNKNOWN

Contact #2

What was Ebola status of *contact?* ☐CONFRIMED ☐ SUSPECTED ☐ UNKNOWN

Amount of time since last contact [____] ☐DAYS ☐ WEEKS

Type of contact: ☐ body fluids ☐ direct physical contact with body

☐ shared items/linens ☐ shared room/home

Is the contact alive or dead? ☐ALIVE ☐ DEAD ☐ UNKNOWN

OTHER MEDICAL HISTORY

Does the patient CURRENTLY have any known co-morbidities? tick all that apply

☐ Tuberculosis ☐ HIV ☐ Heart disease ☐ Diabetes ☐ Asthma

☐ Liver disease ☐ Renal disease ☐ Cancer

Other: _____

Does the patient have any known allergies? ☐ YES ☐ NO ☐ UNKNOWN

If YES, List_____

If patient is FEMALE:

Is the patient currently breastfeeding? ☐ YES ☐ NO ☐ UNKNOWN

Is the patient: ☐ Pregnant ☐ Postpartum (birth in last 6 weeks) ☐ Neither ☐ Unknown

If PREGNANT: **Gestation age of fetus** (nearest week): [__][__] weeks ☐ Unknown

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PRE-EXISTING MEDICATIONS

List all medications patient is taking/prescribed prior to admission (e.g. antibiotics, antivirals, antifungal, antimalarials, analgesic/antipyretics)

Name of medication *(prefer generic name)*	**Dose and frequency**
	☐unknown
	☐unknown
	☐unknown

SIGNS

Bruising	☐Yes ☐No	**Lower chest wall indrawing**	☐Yes ☐No
Pale/Anaemia	☐Yes ☐No	**Abdominal tenderness**	☐Yes ☐No
Jaundice	☐Yes ☐No	**Hepatomegaly**	[_____] cm
Rash	☐Yes ☐No	**Splenomegaly**	[_____] cm
Conjunctival injection	☐Yes ☐No	**Lymphadenopathy**	☐Yes ☐No
Elevated Jugular Venous Pressure (JVP)	☐Yes ☐No		

CLINICAL IMPRESSION

Was the patient critically ill upon arrival? ☐YES ☐NO

Did the patient display any of the following (check all that apply):

☐ Signs of shock ☐ Unconsciousness ☐ Severe dehydration ☐Convulsions

☐ Anxiety/confusion

What is your clinical diagnosis and differential? _____

_____

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CLINICAL MANAGEMENT PLAN

Admit to: ☐ WET ward ☐ DRY ward

Frequency of nursing observations? Every [___] hours

Target oral fluid intake? [_____] ml per 24 hours → [____] ml per hour

***If on IV fluids*, rate of infusion? [_____] ml per 24 hours → [____] ml per hour**

*****REMINDER: FILL THE PRESCRIPTION CHART**

Have you filled the prescription chart? ☐YES ☐NO

Other management? _____

_____

Medications:

☐ **Admissions pack**	☐ **Cefixime**
☐ **Artemether-Lumefantrine (ACT)**	☐ **Metronidazole**
☐ **Artusunate**	☐ **Parecetamol**
☐ **Quinine**	☐**Tramadol**
☐ **Ceftriaxone**	☐ **Morphine**

Other medication? Specify _____

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The latest version of this form can be found at
https://wiki.openmrs.org/display/projects/Paper+forms+for+SCI+ETC