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

PATIENT ID NUMBER: KT – ☐ – ☐☐☐☐☐

WARD #*: _________ BED # ______ ***BEGIN NEW FORM WHEN MOVED TO NEW WARD**

OBSERVATIONS and SIGNS

Time (24 hr) **Date: DD/MM**		__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __
Provider (your) name					
CURRENT Consciousness		A V P U	A V P U	A V P U	A V P U
Temperature °C					
Oxygen saturation (%)					
Respiratory rate breaths/minute					
Heart rate beats/minute					
Systolic BP mmHg					
Diastolic BP mmHg					
Raised JVP (cm)					
Capillary refill time (seconds)					
Abdomen tender?		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Pale/Anaemia		☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev
Hydration	**Oral fluids in past 24 h (mL)**				
	Dehydration	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev
	Urine output (circle)	Normal None Reduced Unk	Normal None Reduced Unk	Normal None Reduced Unk	Normal None Reduced Unk
	Vomiting	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev	☐ None ☐ Mild ☐ Mod ☐ Sev
	Stool freq (#/24 hr)				
	Main stool type	☐Formed ☐Semi-formed ☐Liquid ☐None	☐Formed ☐Semi-formed ☐Liquid ☐None	☐Formed ☐Semi-formed ☐Liquid ☐None	☐Formed ☐Semi-formed ☐Liquid ☐None

Ward #: ________ Bed #: ___ PATIENT ID #: KT --___ -- ___ ___ ___ ___ ___

SYMPTOMS SECTION

Time (24 hr) Date: DD/MM	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __
Overall symptoms	☐Same ☐Better ☐Worse	☐Same ☐Better ☐Worse	☐Same ☐Better ☐Worse	☐Same ☐Better ☐Worse
Fatigue	☐None ☐Mild ☐Mod ☐Sev	☐None ☐Mild ☐Mod ☐Sev	☐None ☐Mild ☐Mod ☐Sev	☐None ☐Mild ☐Mod ☐Sev
Headache	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Joint/muscle pains	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Unable to drink	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Unable to eat	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Difficult to swallow	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Hiccups	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Cough	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Difficult to breathe	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Rash	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Abdominal pain	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Urine pain	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Bleeding?	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
***If yes for bleeding*, which sites?**	☐ Nose/oral ☐ Cough ☐ Vomit ☐ Stool ☐ Vaginal (not menstrual) ☐ Other (list)	☐ Nose/oral ☐ Cough ☐ Vomit ☐ Stool ☐ Vaginal (not menstrual) ☐ Other (list)	☐ Nose/oral ☐ Cough ☐ Vomit ☐ Stool ☐ Vaginal (not menstrual) ☐ Other (list)	☐ Nose/oral ☐ Cough ☐ Vomit ☐ Stool ☐ Vaginal (not menstrual) ☐ Other (list)
Other symptoms (list)				

Ward #: ________ Bed #: ___ PATIENT ID #: KT --___ -- ___ ___ ___ ___ ___

DAILY MANAGEMENT PLAN SECTION

*** ASSUME PATIENT ON STANDARD ORAL TREATMENT PACKAGE UNLESS STATED OTHERWISE**

Time (24 hr) Date: DD/MM	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __	__ __ : __ __ __ __ / __ __
Fluid management 1=ORS; 2=Jelly Water 3=IV Maintenance 4= IV /IO Resuscitate 5= Blood transfusion 6= Fluid Restrict	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
Target volume in next 24 h (mL)				
Antimalarials	☐ AL (ACT) ☐ Artesunate ☐ Quinine	☐ AL (ACT) ☐ Artesunate ☐ Quinine	☐ AL (ACT) ☐ Artesunate ☐ Quinine	☐ AL (ACT) ☐ Artesunate ☐ Quinine
Antibiotics	☐ Ceftriaxone ☐ Cefixime ☐ Metronidazole	☐ Ceftriaxone ☐ Cefixime ☐ Metronidazole	☐ Ceftriaxone ☐ Cefixime ☐ Metronidazole	☐ Ceftriaxone ☐ Cefixime ☐ Metronidazole
Analgesics / Antipyretics	☐ Paracetamol ☐ Tramadol ☐ Morphine	☐ Paracetamol ☐ Tramadol ☐ Morphine	☐ Paracetamol ☐ Tramadol ☐ Morphine	☐ Paracetamol ☐ Tramadol ☐ Morphine
Other (specify)				

Date (DD/MM)	Clinical impression:
___/___	Problem list:
Date (DD/MM)	Clinical impression:
___/___	Problem list:
Date (DD/MM)	Clinical impression:
___/___	Problem list:
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	Problem list:

Ward #: ________ Bed #: ___ PATIENT ID #: KT --___ -- ___ ___ ___ ___ ___

___/___	

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Created by Shefali Oza (shefalita@gmail.com)

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