TRIAGE 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): _____

BASIC PATIENT INFORMATION

Information provided by: ☐ Patient ☐ Someone else

If Someone else: Relation to patient: _____

Patient name: Surname _____ First name _____

Address: District _____ Chiefdom_____ Town/village _____

Sex: ☐ Male ☐ Female

Estimated age: ☐ YEARS ☐ MONTHS (for children under 1 year)

SYMPTOMS and CASE DEFINITION

Number of days since earliest onset of symptoms: ☐ days

Has the patient had:

1. Sudden onset of a high fever? ☐ YES ☐ NO ☐ UNKNOWN

2. Contact with a suspect/probable/known Ebola case? ☐ YES ☐ NO ☐ UNKNOWN

3. Inexplicable bleeding? ☐ YES ☐ NO

4. Any of the following symptoms (check all that apply)?

Headache	☐Yes	☐No	**Vomiting**	☐Yes	☐No
Anorexia/loss of appetite	☐Yes	☐No	**Diarrhoea**	☐Yes	☐No
Lethargy/severe fatigue	☐Yes	☐No	**Stomach pain**	☐Yes	☐No
Aching muscles/joints	☐Yes	☐No	**Difficulty swallowing**	☐Yes	☐No
Breathing difficulty	☐Yes	☐No	**Hiccup**	☐Yes	☐No

**** Case definition met if yes for*** #1 & #2 ***OR*** #3 ***OR*** #1 & three from #4

Does the patient meet the case definition? ☐ YES ☐ NO

If YES: *Complete rest of form and send to assessment*

If NO: *Ask patient to leave ETC*

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ADDITIONAL PATIENT INFORMATION

Can patient eat: ☐Nothing ☐Liquid only ☐Semi-solid food ☐ Solid food

***If Estimated Age is under 12 months (1 year)*:**

Gestation: ☐ Term-born (≥37wk GA) ☐Preterm(<37wk GA) ☐Unknown

Currently breastfed? ☐YES ☐NO ☐Unknown

Is the patient a healthcare worker (anyone involved with patient e.g. nurse, hospital cleaner, ambulance driver)? ☐ YES ☐ NO ☐ UNKNOWN

If YES, **Position**_____ **Name of facility**_____

Location of facility: District _____ Town/Village _____

If NO, **Specify occupation**_____

Did the patient visit another health centre for this illness (including pharmacy)?

☐ YES ☐ NO ☐ UNKNOWN

If YES, **Name of facility** _____ **District**_____

Date visited other facility (DD/MM/YYYY) [__][__]/[__][__]/2014 ☐UNKNOWN

Patient ID # in other facility _____

Location where patient became ill: District_____

Village_____ Chiefdom _____

Next of kin: Name _____ **Mobile #** _____

Address: District _____ Town/village _____

Any children (<18 years) at home without supervision? ☐ YES ☐ NO ☐ UNKNOWN

Number of children: [____] **List ages** _____

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2014-11-04
Created by Shefali Oza (shefalita@gmail.com)

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