ICMR-National Institute of Virology, Pune

Case Reporting Form For Diarrhoea In Patients

(Write data in the respective boxes or tick appropriately)

Centre No [ ][ ] **Site No** [ ][ ] **Serial Number** [ ][ ][ ][ ]

'Unique 8-digit ID'

Please fill all the Mandatory fields marked with an (*)

I. Identification* (as given in the Medical Record)

1. Name of the Reporting Hospital ______________________

2. Medical Record No. ______________

3. Date of Admission [ ][ ]/[ ][ ]/[ ][ ] *(dd/mm/yy)* 4.Time of Admission [ ][ ].[ ][ ] AM PM

5. Primary Diagnosis ______________________

6. Final Diagnosis ______________________

II. Patient Information* (as given in the Medical Record)

7. Patient Name ______________ 8. Guardian Name ______________

9. Address ______________________

10. Town/City ______________ 11.District ______________

12. Age in Years [ ][ ] 13.Date of Birth [ ][ ]/[ ][ ]/[ ][ ][ ][ ] *(dd/mm/yyyy)*

14a. Sex Male [1] Female [2] 14b.Mobile/ Contact No.______________

III. Immunization History

15a. Oral Rotavirus Yes [1] No [0] Don't Know [9] 15b. No. of doses [1] [2] [3]

15c. Name of the vaccine: ROTASIIL [A] ROTATEQ [B] ROTARIX [C] ROTAVAC [D]

15d. Any Other vaccination given simultaneously ______________

IV. Clinical Information on admission*

16. Temperature [ ][ ].[ ] ⁰C (as given in the Medical Record)

17a. Vomiting Yes [1] No [0] 17b. Duration [ ][ ] *days* 17c.No.of Episodes/24hrs [ ][ ]

18a. Diarrhoea Yes [1] No [0] 18b. Duration [ ][ ] *days* 18c.No.of Episodes/24hrs [ ][ ]

19. Urine passed in past 6 hours Yes [1] No [0]

19a. Any history of Intussusception reported ______________

V. Signs of dehydration on admission* (as given in the Medical Record)

20. Lethargy — Yes [1] No [0]

21. Restless — Yes [1] No [0]

22. Feeding well — Yes [1] No [0]

23. Eyes shrunken — Yes [1] No [0]

24. Skin Pinch — Normal [1] Slow return [2] Very slow return [3]

25. Degree of dehydration — None [0] Some [2] Severe [3]

26. Treatment — Oral [1] Intravenous [2]

VI. Discharge Information* (as given in the Medical Record)

27. Date of Discharge/Death [ ][ ] / [ ][ ] / [ ][ ] *(dd/mm/yy)*   28.Time of Discharge [ ][ ] . [ ][ ] [AM][PM]

29. Outcome at Discharge: Recovered [1] Not recovered [2] Died [3] LAMA [4] Unknown5 [ ]

VII. Sample Collection Information

30. Stool Sample Collected: Yes [1] No [0]

31. Date of Sample collection [ ][ ] / [ ][ ] / [ ][ ] *(dd/mm/yy)*

Form completed by: Name ____________________ Designation ________________________

Date ____________________ Signature ________________________

VIII. Laboratory Information

32. Date of Receipt of Sample [ ][ ] / [ ][ ] / [ ][ ] *(dd/mm/yy)*

33. Is Sample Volume Adequate (min 5 g or ml): Yes [1] No [0]

34. Is Rotavirus identified in Stool? Yes [1] No [0]

35. If No, Other Enteric Viruses [ ]

Sample Processed by: Name ____________________ Designation ____________________

Date ____________________ Signature ____________________