

Clinical Data Collection Tool

Health facility ID:				-	Individual ID:					-	Date:							-	2	0		
Day(XX) Month(XXX) Year(XXXX)																						

Patients' village of residence:

Date of Birth:				-					-	Age:			-	Gender:	Male	Female
Day(XX) Month(XXX) Year(XXXX) Years (If less than 1 year, record age in months)																

Number of days since diarrheal episode:

Number of days diarrheal episode lasted:

Number of stools in a 24 hours:	3	4	5	6	7	>7	TNTC
(TNTC -too numerous to count)							

Other symptoms:

Fever ($\geq 38^{\circ}\text{C}$) by caregiver report:	Yes	No	-	Loss of consciousness:	Yes	No	-	Convulsions:	Yes	No	-
Vomiting:	Yes	No	-	Abdominal (belly) pain:	Yes	No	-	Unable to drink:	Yes	No	-
Difficulty breathing:	Yes	No	-	Weight loss:	Yes	No	Unknown	Bloody stools:	Yes	No	-

Received antibiotics before coming to the health facility:	Yes	No	Don't know					
If yes, how many days of antibiotics:	1	2	3	4	5	6	7	Don't know
If less than 1 day, has it been less than 12 hours:	Yes	No						
Antibiotic name: _____								

If the child is <5 years old, did they receive the rotavirus vaccine?	Yes	No	Don't know
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If yes please record the following information from the vaccine card, received rotavirus vaccine:	Yes	Not recorded	If not recorded skip to "Clinic Visit Information"
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If yes, how many doses:	1	Date							-	2	0	
	:											
	2	Date							-	2	0	
	:											
	>2	Date							-	2	0	
	:											
Day(XX) Month(XXX) Year(XXXX)												

Clinic Visit Information (information provided by nurse/study coordinator):

Temperature:	_____	C	Not collected	-	Weight:	_____	Kg	Not collected
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Referred:	Yes	No	-	Admitted:	Yes	No
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Zinc prescribed:	Yes	No	-	Oral rehydration:	Yes	No	-	IV rehydration:	Yes	No
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Antibiotics prescribed:	Yes	No
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Lab Collection Information

Specimen ID:									
Lab ID:									

Collection time:					-	Collection date:			-			-	2	0		
	<i>Time in 24 hours</i>						<i>Day(XX)</i>		<i>Month(XXX)</i>			<i>Year(XXXX)</i>				

Stool collected from:	Directly	Part of already collected specimen	Diaper
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Notes and Comments:

(Initial and date any notes or comments)

Interviewer's Name/Signature: _____

Quality Reviewer's Name/Signature: _____	Quality Review Date:			-			-	2	0		
		<i>Day(XX)</i>		<i>Month(XXX)</i>			<i>Year(XXXX)</i>				

