

SALMONELLA CASE REPORT FORM (CRF)

Patient Information

Patient Bar code

Study ID

Date of Visit

Name of patient (At least two names)

Date of birth

Age

Gender: ☐ Male ☐ Female

Telephone number

Telephone number of a contact

Clinical History

Did you have fever in the past 3 days? ☐ Yes ☐ No ☐

Was it continuous fever? ☐ Yes
☐ No

Symptoms currently (circle/select):

Cough: ☐ Yes ☐ No

Hemoptysis: ☐ Yes ☐ No

Expectoration: ☐ Yes ☐ No

Vomiting: ☐ Yes ☐ No

Abdominal pain: ☐ Yes ☐ No

Distension: ☐ Yes ☐ No

Diarrhea: ☐ Yes ☐ No

Bloody Diarrhea: ☐ Yes ☐ No

Constipation: ☐ Yes ☐ No

Dysuria: ☐ Yes ☐ No

Frequent urination: ☐ Yes ☐ No

Headache: ☐ Yes ☐ No

Seizure: ☐ Yes ☐ No

Sickle cell disease: ☐ Yes ☐ No

Tuberculosis: ☐ Yes ☐ No

Malignancy: ☐ Yes ☐ No

HIV/AIDS: ☐ Yes ☐ No

Dehydration ☐ None ☐ Mild ☐ Moderate ☐ Severe

Medication History

Did you take any medication in the last 8 weeks? ☐ Yes ☐ No

Chloramphenicol: ☐ Yes ☐ No

Amoxicillin: ☐ Yes ☐ No

Co-amoxiclav: ☐ Yes ☐ No

Ciprofloxacin: ☐ Yes ☐ No

Ceftriaxone: ☐ Yes ☐ No

Examination

Heart Rate (beats/min) _____

Temperature (°C) _____

Respiratory rate _____

Height (cm) _____

Weight (kg) _____

Mid arm circumference (cm) _____

Disposition and Laboratory

Patient disposition: ☐ Sent home ☐ Admitted ☐ Died ☐

Absconded/Lost ☐ Transferred

Patient examined by _____

Was HIV test done? ☐ Yes ☐ No ☐ Decline ☐ Known Positive

Result: ☐ Reactive ☐ Non-reactive

Sample type: ☐ Blood ☐ Stool

Time of data entry _____ Date _____

Data entered by _____