ACUTE DIARRHEAL SYNDROME CASE INVESTIGATION FORM

Reporter			
Name of reporter		Name of Health facility	
Phone		Fax	
Date of report ___/ ___ / ___			
Demographic information			
Name of patient		Address of patient:	
Date of birth___/ ___ / ___	Age: _____	Sex: Female □ Male □	
Ethnicity		Nationality:	
Occupation			
If the child under 15 years of age:	Name of father:_____ Age: ___ Occupation: _____	Name of mother:_____ age: ___ Occupation: _____	
Telephone	Mobile	District	Province
Other relevant information (school, workplace etc.)			
Signs and symptoms			
Date of Onset of illness (dd/mm/yy): ___ / ___ / ___ (Onset: the date when any of the following conditions occurred the first time)			
How many times per day did you have diarrhea? _____			

Symptom	**Yes**	**No**	**Don't know**	**Symptom**	**Yes**	**No**	**Don't know**
Abdominal Pain	□	□	□	Fever	□	□	□
Nausea	□	□	□	Salivary discharge	□	□	□
Vomiting	□	□	□	Sweat	□	□	□
Acute watery diarrhea	□	□	□	Back pain	□	□	□
Acute bloody diarrhea	□	□	□	Sunken fontanel's (if baby)	□	□	□
Acute mucous diarrhea	□	□	□	Paralysis			

Other			
Treatment			
Date of treatment: ___/ ___ / ___		Place of treatment: _____	
Treatment receiving:			

History of food							
History of food and drinking in 5 days before illness							
Date	**Morning**		**Afternoon**		**Evening**		
History of suspected food			Source of suspected food				
Number persons that ate suspected food	_____		Number of persons that are ill		_____		
Source of drinking water	Well □	Distilled □	Drilled water □	Piped water □	River □	Other _____	
Type of latrine	Water sealed □	Traditional latrine □	Forest □	River □	Digging hole □		
Laboratory							
Time of stool collection			Date of stool collection		___/ ___ / ___		
Result of stool sample							
Health status							
Recovered □			Hospitalized □		Date___/ ___ / ___		
Died □			Date of death		___/ ___ / ___		

Case classification

1. **Clinically confirmed** □
2. **Epidemiologically confirmed** □
3. **Laboratory confirmed** □

DATE: ___/___/_____

FORM COMPLETED BY: _____