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# Patient Record Form

Clinic \_\_\_\_\_

Date  _ _ / _ _ / _ _	OPD Number  _ _ _ _	Patient's Last Name	First Name	New attendance <input type="checkbox"/> Yes <input type="checkbox"/> No
Parish	Village	Age:  _ _  Yrs  _ _  Mos	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight  _ _   _   _  kg

History & Exam Findings (complete ALL questions)				
Fever or history of fever? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough ≥ 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drenching night sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> BS for Malaria <input type="checkbox"/> Pos <input type="checkbox"/> Neg  Parasite density: _____ (if positive)  <input type="checkbox"/> RDT for Malaria <input type="checkbox"/> Pos <input type="checkbox"/> Neg  Malaria Lab number  _ _ _ _ _	<input type="checkbox"/> HIV test <input type="checkbox"/> CTRR <input type="checkbox"/> CTR  HIV Lab number  _ _ _ _ _	<input type="checkbox"/> TB exam: <u>Date collected:</u> <u>Type</u> <u>Date reported:</u> 1 <sup>st</sup> smear <input type="checkbox"/> Pos <input type="checkbox"/> Neg ___/___/___ <input type="checkbox"/> LM <input type="checkbox"/> FM ___/___/___ 2 <sup>nd</sup> smear <input type="checkbox"/> Pos <input type="checkbox"/> Neg ___/___/___ <input type="checkbox"/> LM <input type="checkbox"/> FM ___/___/___  TB Lab number  _ _ _ _ _
<input type="checkbox"/> Stool ordered - Results:	<input type="checkbox"/> Urinalysis ordered - Results:	<input type="checkbox"/> Hb  _ _ _ _ _  g/dl  <input type="checkbox"/> VDRL test <input type="checkbox"/> Pos <input type="checkbox"/> Neg  <input type="checkbox"/> Other (test/result)

Diagnoses (Check all that apply)			
Reportable Diseases	Infectious Diseases	Non-infectious Diseases	Maternal and Perinatal Diseases
<input type="checkbox"/> Acute flaccid paralysis	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcohol and drug abuse	<input type="checkbox"/> Abortions
<input type="checkbox"/> Cholera	<input type="checkbox"/> Cough or Cold (no pneumonia)	<input type="checkbox"/> Anaemia	<input type="checkbox"/> Haemorrhage during pregnancy
<input type="checkbox"/> Dysentery	<input type="checkbox"/> Diarrhea- Acute	<input type="checkbox"/> Animal and Snake bites	<input type="checkbox"/> High BP during pregnancy
<input type="checkbox"/> Guinea worm	<input type="checkbox"/> Diarrhea- Persistent	<input type="checkbox"/> Asthma	<input type="checkbox"/> Obstructed labour
<input type="checkbox"/> Hemorrhagic fever	<input type="checkbox"/> Intestinal worms	<input type="checkbox"/> Cardiovascular- High BP	<input type="checkbox"/> Perinatal conditions in newborns
<input type="checkbox"/> Measles	<input type="checkbox"/> Leprosy	<input type="checkbox"/> Cardiovascular- Other	
<input type="checkbox"/> Meningitis (Meningococcal)	<input type="checkbox"/> Malaria (not during pregnancy)	<input type="checkbox"/> Childhood mental disorder	Miscellaneous Diseases
<input type="checkbox"/> Plague	<input type="checkbox"/> Malaria (during pregnancy)	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Death in OPD (no diagnosis)
<input type="checkbox"/> Rabies	<input type="checkbox"/> Meningitis (Non meningococcal)	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> ENT Conditions
<input type="checkbox"/> Tetanus (0-28 days age)	<input type="checkbox"/> Onchocerciasis	<input type="checkbox"/> GI disorders (non infectious)	<input type="checkbox"/> Eye Conditions
<input type="checkbox"/> Yellow Fever	<input type="checkbox"/> Pelvic Inflammatory Disease	<input type="checkbox"/> Injuries—Road Traffic Accidents	<input type="checkbox"/> Skin Conditions
	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Injuries—Trauma of other Origin	<input type="checkbox"/> Oral Diseases and conditions
	<input type="checkbox"/> Schistosomiasis	<input type="checkbox"/> Malnutrition- low weight for age	
	<input type="checkbox"/> Sleeping Sickness	<input type="checkbox"/> Malnutrition- severe	Other Cough Diagnoses
	<input type="checkbox"/> STI	<input type="checkbox"/> Mental Illness- Anxiety	<input type="checkbox"/> Acute Bronchitis/LRTI (no pneumonia)
	<input type="checkbox"/> Tetanus (over 28 days age)	<input type="checkbox"/> Mental Illness- Depression	<input type="checkbox"/> Allergic Rhinitis
	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Mental Illness- Mania	<input type="checkbox"/> COPD
	<input type="checkbox"/> Urinary Tract Infections (UTI)	<input type="checkbox"/> Mental Illness- Schizophrenia	<input type="checkbox"/> Heartburn
		<input type="checkbox"/> Mental Illness- Other	
Other Diagnosis			

Treatment (Check all that apply). For antimalarial drugs, Tick DA if Drug is Available and given or Tick OS if Drug is Out of Stock or Tick ANG if Drug is Available but not Given			
Drug	Dose	Drug	Dose
<b>Antimalarial</b>	<b>DA OS ANG</b>	<b>Other Drugs</b>	
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Aspirin	
<input type="checkbox"/> Quinine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Cough linctus	
<input type="checkbox"/> Chloroquine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Diazepam	
<input type="checkbox"/> Amodiaquine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Dexamethasone	
<input type="checkbox"/> SP	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Diclofenac	
<input type="checkbox"/> Artesunate	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Folic Acid	
<input type="checkbox"/> DP	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Gentian violet	
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Hydrocortisone	
<b>Antimicrobials</b>		<input type="checkbox"/> Ibuprofen	
<input type="checkbox"/> Albendazole		<input type="checkbox"/> Magnesium	
<input type="checkbox"/> Amoxicillin		<input type="checkbox"/> Multivitamin	
<input type="checkbox"/> Chloramphenicol		<input type="checkbox"/> Nystatin	
<input type="checkbox"/> Ciprofloxacin		<input type="checkbox"/> Paracetamol	
<input type="checkbox"/> Cloxacillin		<input type="checkbox"/> Phenytoin	
<input type="checkbox"/> Cotrimoxazole		<input type="checkbox"/> chloramphenicol	
<input type="checkbox"/> Doxycycline		<input type="checkbox"/> Salbutamol	
<input type="checkbox"/> Erythromycin		<input type="checkbox"/> Vit. B group	
<input type="checkbox"/> Gentamicin		<input type="checkbox"/>	
<input type="checkbox"/> Mebendazole		Other	
<input type="checkbox"/> Metronidazole		Other	
<input type="checkbox"/> PPF		Other	
<input type="checkbox"/> Tetracycline		Other	
<input type="checkbox"/> X-pen		Other	

Referrals and additional notes		TB Drug Regimen (Check if prescribed)			
<input type="checkbox"/> Admitted to ward	Notes	<b>Initiation:</b>	<b>DA OS ANG</b>	<b>Continuation:</b>	<b>DA OS ANG</b>
<input type="checkbox"/> Referred to HIV care		<input type="checkbox"/> RHZE	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> HE	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Referred for TB care		<input type="checkbox"/> RHZES	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> RHE	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Referred for other services		<input type="checkbox"/> RHZ	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> RH	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Full Name

Signature