MOH502

MINISTRY OF HEALTH KENYA
Integrated Case Based Surveillance Form

ED2020

Use this form for a single case only
Duly complete the form before submission

(To be completed at the National level)
EPID No: ....
Country County Sub County Year
Date form received at national level _____/_____/_____

A. Name of Site Reporting & Disease being reported

A1. Health Facility ..... **A2**. Type .....
A3. Sub County ..... **A4**. County .....
A5. Disease reported (Tick One)

☐ AFP ☐ NNT ☐ Measles ☐ Meningitis ☐ Plague ☐ VHFs ☐ Yellow Fever ☐ S. AI ☐ Other (Specify) .....

NB: If you suspect AI, Please fill the Avian Influenza Case Investigation form

B. Identification

B1. Name of patient .....
B2. Sex: ☐ 1 = Male 2 = Female **B3**. Age in ☐ Years ☐ Months ☐ Days
B4. D.O.B. ____/___/___
B5. Residence: ☐ Urban ☐ Rural
B6.Tracer information:
a. Parent/Guardian: .....
b. Residence (Village/Hse No): .....
c. Neighborhood major landmark: .....
d. Street/Plot/Estate/S. location: .....
e. Town/City/Location: .....
f. Sub County: ..... County: .....
g. Telephone No of parent/guardian: .....

C. Clinical Information

C1. Date of onset of illness _____/_____/_____
C2. Date first seen at health facility: _____/_____/_____
C3. Date Health facility notified sub County level: ____/_____/_____
C4. Hospitalized: 1= Yes 2=No Date of Admission _____/___/____
C5. IP/OP No. .....
C6. Diagnosis: .....
C7. Means of diagnosis: ☐ Clinical ☐ Lab ☐ Epi linkage ☐ Other (specify): .....

C8. Vaccination History for disease under investigation [Measles, AFP (exclude birth dose of OPV), NNT (TT in mother), Yellow fever, Meningitis and suspected Avian Influenza]

a. Was the patient vaccinated against illness (including campaign)? ☐
1 = Yes 2=No 9= unknown. If yes, no of doses: .....

b. Any vaccination given in the last two months? ☐ 1= Yes 2= No 9= unknown. Date of vaccination ____/___/____

C9. Status of the patient:
☐ Still hospitalized ☐ Discharged ☐ Dead

D. For Acute Flaccid Paralysis (AFP) Case Only
(To be filled by a clinician only)

D1. Date of onset of paralysis: _____/_____/_____

D2. Signs and symptoms: 1 = Yes 2 = No
☐ Fever at onset of paralysis ☐ Sudden onset of paralysis
☐ Paralysis progressed < 3 days ☐ Flaccid (floppy)

D3. Site(s) of paralysis: ☐ Left leg ☐ Right leg ☐ Left arm ☐ Right arm

Name .....**Tel. No**.....

D4. **Follow-up Examination** to be done after 60 days from onset of paralysis using the 60 days follow up form

E. For Neonatal Tetanus Case Only

E1. Delivery practices

a. Where was the baby delivered?
☐ Health facility (Name): .....
☐ Home by trained attendant ☐ Home by untrained attendant
☐ Unknown

b. Was the cord cut with sterile/clean blade? ☐
1=Yes 2=No 9=Unknown

c. How was the cord stump treated or dressed? .....

E2. Baby's symptoms

a. How old (in days) was the baby when the symptoms began?
☐ Days ☐ Unknown

b. At birth, did the baby suck normally? ☐ 1=Yes 2=No 9=Unknown

c. Was the case confirmed as neonatal tetanus (if yes to the last 3 questions)? ☐ 1=Yes 2=No 9=Unknown

E3. Treatment

a. Was the baby treated at a health facility? ☐ 1=Yes 2=No 9=Unknown

b. Is the mother alive? ☐ 1=Yes 2=No 9=Unknown
(If no, complete case investigation form for maternal deaths)

E4. Case Response: [Sensitize TBAs and community leaders on safe delivery practices and cord care. Provide booster TT doses to mother of NNT case and women of child-bearing age in community.]

a. Did case response for the mother take place? ☐
1=Yes 2=No 9=Unknown

b. Did a case response take place in her community? ☐
1=Yes 2=No 9=Unknown

F. For Measles Case Only

F1. Presence of fever: ☐ 1=Yes 2=No
F2. Date of onset of rash: _____/_____/_____
F3. Type of rash: ☐ Maculopapular ☐ Other
F4. Was home of patient visited for contact investigation?
☐ Yes (Date): _____/_____/_____ ☐ No
F5. Is the case epidemiologically linked to a lab-confirmed case?
☐ Yes ☐ No ☐ Unknown

G. laboratory Information

G1. Specimen collection *(To be completed by the health facility)*
If lab specimen was collected, complete the following information and send a copy of this form to the lab with the specimen
For AFP don't collect specimen if onset of paralysis is more than 60 days old

a. Was specimen collected? ☐ 1=Yes 2= No
If no, why? .....
.....

b. Date(s) of specimen collection: __ /__ /__ and __ /__ /__

c. Specimen type: ☐ Stool ☐ Blood ☐ CSF ☐ OPS ☐ NS ☐ Animal tissue ☐ other (specify .....

d. Date specimen send to the lab: _____/_____/_____

e. Name of the lab: .....

G2. Lab results
☐ Received (provide).....
☐ Not yet received

H. Sub County Contact Person

H1. Form completed by: .....
Designation: ..... Sign: .....
H2. Sub County contact person details:
Name: .....
Designation: ..... Phone No: .....
Email: .....

Final Laboratory Results
(Please indicate the final laboratory results in detail)

NS: Nasal Swab
OPS: Oropharyngeal Swab
S. AI: Suspected Avian Influenza

Comments: _____

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