

One Health Consortium Project

Case Performa (Hospital/Community),

Case ID _____

Name of the Centre: _____,

Date: ____/____/20____

A. Case Identification:

Name of the Hospital (For IPD/OPD): _____

Patient's Name: _____ Sex: F/ M Age: _____ Years _____ months

Religion: _____ Caste: Gen / SC/ ST/ OBC

Parent's name: _____

--	--	--	--	--	--

Res. Address: _____

PIN:

Landmark: _____

Village/ Mohalla: _____

Block/Urban area: _____

District: _____ Setting: Rural/ Urban

State: _____

Mob.

--	--	--	--	--	--	--	--	--	--	--

No.:

GIS co-ordinates: (Latitude) _____ (Longitude) _____ (Community survey only)

Hospital Registration no (where applicable):- _____

Has there been reported outbreak of similar cases in last 3Months from the same area? Y/ N/ UK, if yes, specify:

Contact with animals with zoonotic disease like Bovine-Tb/others: Y/ N/ DK

B. Occupational/ other Exposures (reference period preceding 3 months)

a. Occupation at date of onset of illness

- 1.Agriculture Farming
- 2.Dairy
- 3.Livestock rearing
- 4.Veterinarian
- 5.Slaughterhouse worker
- 6.Live in household with person occupationally related to above
- 7. Contact with wild animals
- 8.Other (please specify)-

b. Any contact with animals within 3 months prior to onset (Check all that apply)

- 1.Cattle
- 2.Goats
- 3.Cats
- 4.Sheep
- 5.Pigeon
- 6.Poultry
- 7.Rodents/guinea pig
- 8.Rabbit
- 9.Pig
- 10. Dog
- 11.Others (please specify) _____

One Health Consortium Project
Case Performa (Hospital/Community), Case ID _____

c. Any exposure to delivery/abortion of animals- <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. UK If Yes, which animal: _____	d. Exposure to raw/unpasteurized milk? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. UK If Yes, which animal: _____	e.1.Travel during last 90 days before the onset of illness: <input type="checkbox"/> Yes/ <input type="checkbox"/> No 2.If yes, a. Place/s of visit _____ b. Tentative date of visit _____ c. Duration of visit _____	e.Other family member with similar illness in last 3 months <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. UK
---	---	---	---

C. Clinical features

f. <input type="checkbox"/> Symptomatic/ <input type="checkbox"/> Asymptomatic (community survey) g. Date of Onset of presenting Complaint _____ (dd/mm/yyyy)	h. Clinical Symptoms in symptomatic (check all that is applicable) <i>(Evidence of clinically compatible illness is necessary. See attached case definition, and case categorization summaries.)</i> 1.Fever: <input type="checkbox"/> Y/ <input type="checkbox"/> N, if Yes, Date of Onset of Fever _____(dd/mm/yyyy) 2. Myalgia: <input type="checkbox"/> Y/ <input type="checkbox"/> N 3. Retro bulbar pain: <input type="checkbox"/> Y/ <input type="checkbox"/> N 4. Night sweats: <input type="checkbox"/> Y/ <input type="checkbox"/> N 5. Weight loss: <input type="checkbox"/> Y/ <input type="checkbox"/> N 6. Loss of appetite: <input type="checkbox"/> Y/ <input type="checkbox"/> N 7. Chills: <input type="checkbox"/> Y/ <input type="checkbox"/> N 8. Cough>2W: <input type="checkbox"/> Y/ <input type="checkbox"/> N 9. Pain in Chest: <input type="checkbox"/> Y/ <input type="checkbox"/> N 10. Hemoptysis: <input type="checkbox"/> Y/ <input type="checkbox"/> N 11. Dyspnea: <input type="checkbox"/> Y/ <input type="checkbox"/> N 12. Vomiting: <input type="checkbox"/> Y/ <input type="checkbox"/> N 13. Pneumonia: <input type="checkbox"/> Y/ <input type="checkbox"/> N 14. Headache: <input type="checkbox"/> Y/ <input type="checkbox"/> N 15. Rash: <input type="checkbox"/> Y/ <input type="checkbox"/> N 16. Eschar: <input type="checkbox"/> Y/ <input type="checkbox"/> N if Yes, site of eschar _____ 17. Splenomegaly <input type="checkbox"/> Y/ <input type="checkbox"/> N 18. Hepatomegaly: <input type="checkbox"/> Y/ <input type="checkbox"/> N 19. Seizure/convulsion developed*: <input type="checkbox"/> Y/ <input type="checkbox"/> N; if Yes, Date of Onset _____(dd/mm/yyyy) 20. Change in Mental Status*: <input type="checkbox"/> Y/ <input type="checkbox"/> N ; 21. Neck rigidity: <input type="checkbox"/> Y/ <input type="checkbox"/> N 22. Paralysis*: <input type="checkbox"/> Y/ <input type="checkbox"/> N if Yes, Site of paralysis*: <input type="checkbox"/> RA/ <input type="checkbox"/> LA/ <input type="checkbox"/> RL/ <input type="checkbox"/> LL/ <input type="checkbox"/> neck/ <input type="checkbox"/> bulbar/ <input type="checkbox"/> respiratory muscles/ <input type="checkbox"/> trunk/ <input type="checkbox"/> facial/ <input type="checkbox"/> others: _____
---	--

One Health Consortium Project

Case Performa (Hospital/Community), Case ID _____

	23. Diarrhea: <input type="checkbox"/> Y/ <input type="checkbox"/> N if Yes, duration of Diarrhea _____(days) 24. Abdominal cramps: <input type="checkbox"/> Y/ <input type="checkbox"/> N 25. Vomiting: <input type="checkbox"/> Y/ <input type="checkbox"/> N 26. Back pain: <input type="checkbox"/> Y/ <input type="checkbox"/> N 27. Joint pain: <input type="checkbox"/> Y/ <input type="checkbox"/> N 28. Red eyes: <input type="checkbox"/> Y/ <input type="checkbox"/> N 29. Flushed face: <input type="checkbox"/> Y/ <input type="checkbox"/> N 30. Red throat: <input type="checkbox"/> Y/ <input type="checkbox"/> N 31. Petechiae (red spots) on the palate: <input type="checkbox"/> Y/ <input type="checkbox"/> N 32. Sore throat: <input type="checkbox"/> Y/ <input type="checkbox"/> N 33. Dizziness: <input type="checkbox"/> Y/ <input type="checkbox"/> N 34. Drowsiness: <input type="checkbox"/> Y/ <input type="checkbox"/> N 35. Other (please specify) _____		
Any pre-existing medical conditions? (Multiple response) <input type="checkbox"/> 1. Immunocompromised____ <input type="checkbox"/> 2. Valvular HD/Vasc Graft____ <input type="checkbox"/> 3. Diabetes____ <input type="checkbox"/> 4. Pregnancy____ <input type="checkbox"/> 5. Oral steroid____ <input type="checkbox"/> 6. CKD____ <input type="checkbox"/> 7. Other____	Was patient hospitalized because of this illness? <input type="checkbox"/> Y/ <input type="checkbox"/> N/ <input type="checkbox"/> DK,	Did patient die from complications of this illness? * <input type="checkbox"/> Y/ <input type="checkbox"/> N/ <input type="checkbox"/> DK, If yes, date _____ (dd/mm/yyyy) [Keep copy of death certificate if possible]	

D. Laboratory investigations (Specifically for One Health Consortium)

i. Collection of specimen type-						
4. Blood____ 2. CSF____ 3. Sputum____ 4. Stool____ 5. Others (please specify)____						
j. Investigation for	Microscopy	Serology			PCR	Culture
	(Positive/Negative/ Not Done)	(Positive/Negative/ Not Done)			(Positive/Negative/ Not Done)	(Positive/Negative/ Not Done)
	e/ Not Done)	IgM	IgG	IFA	e/ Not Done)	e/ Not Done)
Tuberculosis (Bovine TB)						
Brucellosis						
Japanese encephalitis						

One Health Consortium Project

Case Performa (Hospital/Community), Case ID _____

Scrub typhus				
Q fever				
Cysticercosis				
Salmonellosis (NTS)				
Cryptosporidiosis				
CCHF				
Nipah				
Listeriosis				

E. Vaccination Record

1. BCG Vaccination ____ 1. Yes 2. No 3. Unk if Yes, Date/ Year of Vaccination
 _____(dd/mm/yyyy)

2. JE Vaccination ____ 1. Yes 2. No 3. Unk if Yes, Date/Year of Vaccination
 _____(dd/mm/yyyy)

Diagnosis: (as per record / lab investigation)

1.1 Probable diagnosis: _____

2.1 Confirmed diagnosis: _____

Outcome (as per available records):

Discharged/ LAMA/ Referred out/ Death / not admitted (Rx at OPD)

Signature of data collector

One Health Consortium Project
Case Performance (Hospital/Community), Case ID _____