ICMR-National Institute of Virology, Pune

Case Reporting Form For Diarrhoea In Patients

(Write data in the respective boxes or tick appropriately)

Centre No Site No Serial Number

☐☐ ☐☐ ☐☐☐☐

'Unique 8-digit ID'

Please fill all the Mandatory fields marked with an (*)

I. Identification* (as given in the Medical Record)

1. Name of the Reporting Hospital _____

2. Medical Record No. _____

3. Date of Admission ☐☐/☐☐/☐☐ ***(dd/mm/yy)*** **4.Time of Admission** ☐☐.☐☐ **AM PM**

5. Primary Diagnosis _____

6. Final Diagnosis _____

II. Patient Information* (as given in the Medical Record)

7. Patient Name _____ **8. Guardian Name**_____

9. Address _____

10. Town/City _____ **11.District**_____

12. Age in Years ☐☐ **13.Date of Birth** ☐☐/☐☐/☐☐☐☐ ***(dd/mm/yyyy)***

14a. Sex Male [1] **Female** [2] **14b.Mobile/ Contact No.**_____

III. Immunization History

15a. Oral Rotavirus Yes [1] **No** [0] **Don't Know** [9] **15b. No. of doses** [1] [2] [3]

15c. Name of the vaccine: ROTASIIL [A] **ROTATEQ** [B] **ROTARIX** [C] **ROTAVAC** [D]

15d. Any Other vaccination given simultaneously _____

IV. Clinical Information on admission*

16. Temperature ☐☐.☐ **^{0}C** (as given in the Medical Record)

17a. Vomiting Yes [1] **No** [0] **17b. Duration** ☐☐ ***days*** **17c.No.of Episodes/24hrs** ☐☐

18a. Diarrhoea Yes [1] **No** [0] **18b. Duration** ☐☐ ***days*** **18c.No.of Episodes/24hrs** ☐☐

19. Urine passed in past 6 hours Yes [1] **No** [0]

19a. Any history of Intussusception reported _____

V. Signs of dehydration on admission* (as given in the Medical Record)

20. Lethargy — Yes [1] No [0]

21. Restless — Yes [1] No [0]

22. Feeding well — Yes [1] No [0]

23. Eyes shrunken — Yes [1] No [0]

24. Skin Pinch — Normal [1] Slow return [2] Very slow return [3]

25. Degree of dehydration — None [0] Some [2] Severe [3]

26. Treatment — Oral [1] Intravenous [2]

VI. Discharge Information* (as given in the Medical Record)

27. Date of Discharge/Death [ ][ ]/[ ][ ]/[ ][ ] *(dd/mm/yy)* 28. Time of Discharge [ ][].[ ][ ] AM PM

29. Outcome at Discharge: Recovered [1] Not recovered [2] Died [3] LAMA [4] Unknown5 [ ]

VII. Sample Collection Information

30. Stool Sample Collected: Yes [1] No [0]

31. Date of Sample collection [ ][ ]/[ ][ ]/[ ][ ] *(dd/mm/yy)*

Form completed by: Name _____ Designation _____

Date _____ Signature _____

VIII. Laboratory Information

32. Date of Receipt of Sample [ ][ ]/[ ][ ]/[ ][ ] *(dd/mm/yy)*

33. Is Sample Volume Adequate (min 5 g or ml): Yes [1] No [0]

34. Is Rotavirus identified in Stool? Yes [1] No [0]

35. If No, Other Enteric Viruses [ ]

Sample Processed by: Name _____ Designation _____

Date _____ Signature _____