

Sentinel Surveillance for Diarrhea Etiologic Agents

Case Investigation Form

Lab ID:

Date of hospital visit:

DEMOGRAPHY		
Name:	Age:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Occupation:	
Residential address:	District:	
Contact Number:		
OPD/IPD:	Category: Surveillance <input type="checkbox"/> Outbreak <input type="checkbox"/>	
Date of onset of illness:		
CLINICAL INFORMATION		
Syndrome	Yes	No
Watery diarrhea		
Bloody diarrhea		
Loose diarrhea		
Persistent diarrhea (last 2-4 weeks)		
Chronic diarrhea (last more than 4 weeks)		
Suspected foods/drinks consumed in the past 72 hours: Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, specify (name the food/drinks):		
Travel history: Yes <input type="checkbox"/> No <input type="checkbox"/>		
If Yes, Place name:		Date :
LABORATORY RESULT		
Stool R/E:		
Color:		
Consistency: Watery <input type="checkbox"/> Loose <input type="checkbox"/> Formed <input type="checkbox"/>		
Mucus seen: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Blood seen: Yes <input type="checkbox"/> No <input type="checkbox"/>		
RBCs..... /HPF		
WBCs...../HPF		
Ova/cyst.....		
Others.....		
Culture and AST if performed:		
Sample aliquot in cryo tube?: Yes No		
Date of shipment to RCDC:		
Specimen processed by (Name of Lab personnel):		