World Health Organization

I. CASE IDENTIFICATION/ DEMOGRAPHIC DETAILS

Patient Name: _____	Hospital Name: _____	Local government area (LGA): _____
EPI ID:		
☐ Male ☐ Female	Patient occupation ☐ Healthcare worker. Please specify: _____ ☐ Non-Healthcare worker. Please specify: _____	
Date of birth: (dd/ mm/ yyyy) ____ /____ /_____	If date of birth unavailable, please indicate age in month or years (*mark an X by one*): Age: _____ ☐ Years ☐ Months	
Date of admission: (dd/mm/yyyy) ____ /____ /_____	Was patient transferred from another facility? ☐ Yes ☐ No ☐ Unknown. If yes, name of facility _____	

II. VITALS AT TRIAGE:

Heart rate (bpm): _____	Respiratory Rate (rr/min): _____	Temperature (°C): _____
BP (mmHg): _____ (systolic) _____ (diastolic)	O_2 saturation room air (%):_____	Mental status: GCS_____
Capillary refill > 3 sec? ☐ Yes ☐ No	Weight (kg): _____ Self-reported height (cm): _____	Mid-upper arm circumference (MUAC) (cm) _____

III. CLINICAL DETAILS (on admission)

Date onset first symptoms (dd/mm/yyyy): ____ /____ /_____	If female patient, is she pregnant? ☐ Yes ☐ No ☐ ND
Post-partum (up to 6 weeks)? ☐ Yes ☐ No	If yes, delivery date (dd/mm/yyyy): ____ /____ /_____
Date of admission to isolation unit (dd/mm/yyyy): ____ /____ /_____	Admitted to what type of bed? ☐ Ward ☐ ICU

Comorbid conditions

Tuberculosis	☐ Yes ☐ No ☐ Unknown		Malignancy/Chemotherapy	☐ Yes ☐ No ☐ Unknown	
Asplenia	☐ Yes ☐ No ☐ Unknown		Chronic heart failure including congenital disease	☐ Yes ☐ No ☐ Unknown	
Hepatitis	☐ Yes ☐ No ☐ Unknown				
Diabetes	☐ Yes ☐ No ☐ Unknown		Chronic pulmonary disease	☐ Yes ☐ No ☐ Unknown	
HIV	☐ Yes ☐ No ☐ Unknown		Chronic kidney disease	☐ Yes ☐ No ☐ Unknown	
If yes, on ART?	☐ Yes ☐ No ☐ Unknown		Chronic neurologic condition	☐ Yes ☐ No ☐ Unknown	
Chronic liver disease	☐ Yes ☐ No ☐ Unknown		Other, specify _____		

Symptoms (on presentation)

Fever	☐ Yes ☐ No ☐ Unknown		Sore throat	☐ Yes ☐ No ☐ Unknown	
Weakness	☐ Yes ☐ No ☐ Unknown		Headache	☐ Yes ☐ No ☐ Unknown	
Malaise	☐ Yes ☐ No ☐ Unknown		Chest pain	☐ Yes ☐ No ☐ Unknown	
Myalgia	☐ Yes ☐ No ☐ Unknown		Cough	☐ Yes ☐ No ☐ Unknown	
Anorexia (i.e. loss of appetite)	☐ Yes ☐ No ☐ Unknown		If cough, productive of sputum?	☐ Yes ☐ No ☐ Unknown	
Diarrhoea	☐ Yes ☐ No ☐ Unknown				
Nausea	☐ Yes ☐ No ☐ Unknown				
Vomiting	☐ Yes ☐ No ☐ Unknown				
Irritability / Confusion	☐ Yes ☐ No ☐ Unknown				
Body pain	☐ Yes ☐ No ☐ Unknown				
Joint Pain	☐ Yes ☐ No ☐ Unknown				

Signs (on presentation)

Pharyngeal erythema	☐ Yes ☐ No ☐ Unknown		Enlarged lymph nodes	☐ Yes ☐ No ☐ Unknown	
Pharyngeal exudate	☐ Yes ☐ No ☐ Unknown		If yes, distribution_____		
Conjunctival injection/bleeding	☐ Yes ☐ No ☐ Unknown		Lower extremity oedema	☐ Yes ☐ No ☐ Unknown	
Oedema of face/neck	☐ Yes ☐ No ☐ Unknown		Bleeding	☐ Yes ☐ No ☐ Unknown	
Tender abdomen	☐ Yes ☐ No ☐ Unknown		If yes, site of bleeding: _____		
Sunken eyes or fontanelle	☐ Yes ☐ No ☐ Unknown		Nose	☐ Yes ☐ No ☐ Unknown	
Tenting on skin pinch	☐ Yes ☐ No ☐ Unknown		Mouth	☐ Yes ☐ No ☐ Unknown	
Palpable liver	☐ Yes ☐ No ☐ Unknown		Vagina	☐ Yes ☐ No ☐ Unknown	
Palpable spleen	☐ Yes ☐ No ☐ Unknown		Rectum	☐ Yes ☐ No ☐ Unknown	
Rash	☐ Yes ☐ No ☐ Unknown		Sputum	☐ Yes ☐ No ☐ Unknown	
Jaundice	☐ Yes ☐ No ☐ Unknown		Urine	☐ Yes ☐ No ☐ Unknown	
			Other, specify _____		

IV. SPECIMEN COLLECTION AND RESULTS

Specimen collection done? ☐ Yes ☐ No. If yes, what samples? ☐ Blood ☐ Urine ☐ Buccal swab Other_____

Lassa fever testing	**Collection date** (dd/mm/yyyy)	**Result**
Lassa PCR (admission)	____ /____ /_____	☐ Pos ☐ Neg ☐ indeterminate. Cycle threshold_____
Lassa PCR (Repeat 1)	____ /____ /_____	☐ Pos ☐ Neg ☐ indeterminate. Cycle threshold_____
Lassa PCR (Repeat 2)	____ /____ /_____	☐ Pos ☐ Neg ☐ indeterminate. Cycle threshold_____
Lassa PCR (Repeat 3)	____ /____ /_____	☐ Pos ☐ Neg ☐ indeterminate. Cycle threshold_____

This Rapid Case Management form was developed in collaboration with Nigeria Center for Disease Control, the Irrua Specialist Teaching Hospital, the Federal Medical Center Owo, the Federal Teaching Hospital Abakaliki and the EDCARN network.

Malaria RDT	_____/_____/_____	☐ Pos ☐ Neg ☐ indeterminate
Blood culture	_____/_____/_____	☐ Pos ☐ Neg ☐ indeterminate

Did patient test positive for any other infection? ☐ Yes ☐ No If Yes, specify_____

Other clinical laboratory tests done on admission (ND = not done)

Haemoglobinuria ☐ Pos ☐ Neg ☐ ND
Proteinuria ☐ Pos ☐ Neg ☐ ND
Hematuria ☐ Pos ☐ Neg ☐ ND

Blood Gas ☐ ND ☐ Arterial ☐ Venous ☐ pH_____, pCO2_____, PaO2 ___HCO3_____
Oxygen therapy at time of blood gas (L/min) _____

Laboratory tests from admission or Hospital Day 1(HD1). (ND = not done). If repeat test done, then add Yes or No.

	Admission / HD1	Repeated		Admission / HD1	Repeated
ALT/SGPT (U/L)	☐ ND _____	☐ Yes ☐ No	Lactate (mmol/L)	☐ ND _____	☐ Yes ☐ No
AST/SGO (U/L)	☐ ND _____	☐ Yes ☐ No	Haemoglobin (g/L)	☐ ND _____	☐ Yes ☐ No
Creatinine (µmol/L)	☐ ND _____	☐ Yes ☐ No	Total bilirubin (µmol/L)	☐ ND _____	☐ Yes ☐ No
Potassium (mmol/L)	☐ ND _____	☐ Yes ☐ No	WBC count (x10^9/L)	☐ ND _____	☐ Yes ☐ No
Urea (mmol/L)	☐ ND _____	☐ Yes ☐ No	Platelets (x10^9/L)	☐ ND _____	☐ Yes ☐ No
Creatinine kinase (U/L)	☐ ND _____	☐ Yes ☐ No	PT	☐ ND _____	☐ Yes ☐ No
Calcium (mmol/L)	☐ ND _____	☐ Yes ☐ No	aPTT (seconds)	☐ ND _____	☐ Yes ☐ No

V. Complications at any time (OD= onset date, format: dd/mm/yyyy)

Bleeding	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Coma (GCS < 8)	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Shock	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Bacteraemia	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Meningitis*	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Hyperglycemia	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Confusion	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Hypoglycemia	☐ Yes ☐ No ☐ Unknown	OD___/____/_____
Seizure	☐ Yes	☐ No	☐ Unknown	OD___/____/_____	Other, specify _____		OD___/____/_____

***meningitis defined either clinically or with lumbar puncture**

VI. TREATMENT INFORMATION: (please include loading dose, maintenance and switch to oral therapy)

Did patient receive ANY antimicrobial/antiviral therapy? ☐ Yes ☐ No

Type	Dose	Route	Frequency	Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
Ribavirin		☐ IV ☐ oral	☐ once ☐ Q6H ☐ Q8H	___/____/_____	___/____/_____
		☐ IV ☐ oral	☐ once ☐ Q6H ☐ Q8H	___/____/_____	___/____/_____
		☐ IV ☐ oral	☐ once ☐ Q6H ☐ Q8H	___/____/_____	___/____/_____
		☐ IV ☐ oral	☐ once ☐ Q6H ☐ Q8H	___/____/_____	___/____/_____
		☐ IV ☐ oral	☐ once ☐ Q6H ☐ Q8H	___/____/_____	___/____/_____
Antibacterial: ☐ Yes ☐ No Specify: _____		☐ IV ☐ oral		___/____/_____	___/____/_____
Antimalarial: ☐ Yes ☐ No Specify: _____		☐ IV ☐ oral		___/____/_____	___/____/_____
Other: Specify: _____		☐ IV ☐ oral		___/____/_____	___/____/_____

At any time during the hospitalization, did the patient receive any of the following?

Oral rehydration salts ☐ Yes ☐ No	IV fluid therapy ☐ Yes ☐ No	Access type ☐ Intra-osseous ☐ PIV ☐ CVC
Blood transfusion ☐ Yes ☐ No	Oxygen therapy ☐ Yes ☐ No	Invasive mechanical ventilation ☐ Yes ☐ No
Renal replacement therapy ☐ Yes ☐ No		Vasopressors/inotropes ☐ Yes ☐ No

VII. DISCHARGE DETAILS

Date of Discharge/transfer from health facility/death (dd/mm/yyyy): ____ /_____/_____

Final Diagnosis: ☐ Lassa fever ☐ Other (specify)

Outcome at discharge

☐ Full recovery withOUT sequelae at time of discharge

☐ Full recovery WITH sequelae If yes, specify: ☐ hearing loss ☐ if pregnant, spontaneous abortion ☐ other: _____

☐ Dead

☐ Referred to another facility. If yes, which facility: _____

☐ Left against medical advice

Form completed by: _____