EVD POST-INFECTION
DATA MODULES

The following pages are a part of the CORE CLINICAL DATASET for Ebolavirus disease (EVD). The data segments are divided into modules focused on specific aspects of care. Any combination of modules can be used, depending on the resources or focus of the site and the needs of its patients. The online data management system at www.CliResDMS.org allows you to select the modules you want to complete electronically at your site and generate an electronic dataset while retaining full ownership.

For more information about this dataset, harmonized data standards for EVD, and data capture software please contact isaric@oucru.org. If you would like to suggest a new module for inclusion in these forms please get in touch.

GENERAL INSTRUCTIONS

PARTICIPANT IDENTIFICATION NUMBERS

- All patients should be assigned a unique alpha-numeric identifier (called the Participant Identification Number) to be entered at the top of each module. A clinic or group of clinics sharing dataset access must ensure that each Participant Identification Number are unique across all clinics.
- Each clinic (or clinics if a group of clinics are sharing access to a single dataset) will be assigned a code in order to enter data to the online database. This clinic code will be added at the start of the Patient Identification Number to ensure that patient codes are unique across all sites. E.g. site code 136 and patient code PL0485 will be combined to create the final Patient Identification code 136-PL0485. Site codes are for the purpose of data management only.
- In the case of a participant transferring between clinics, it is preferred to maintain the same Participant Identification Number.
- Complete every line of every section, except for where the instructions say to skip a section based on certain responses.

PAPER COMPLETION INSTRUCTIONS

- We recommend writing clearly in ink, using BLOCK-CAPITAL LETTERS.
- Place an "X" when you choose the correct answer. To make corrections, strike through (-------) the data you wish to delete and write the correct data above it. For research-quality data, initial and date all corrections.
- Please keep all of the sheets for a single participant together e.g. with a staple or participant-unique folder.

GENERAL INSTRUCTIONS

- Selections with square boxes (□) are single selection answers (choose one answer only). Selections with circles (O) are multiple selection answers (choose as many answers as are applicable).
- Mark 'N/A' for any results that are not available, not applicable or unknown. For laboratory values, enter 'N/A' in the data space when results are not available, not applicable or unknown.
- Avoid recording data outside of the dedicated areas as it cannot be captured on the dataset.
- Please enter data on the electronic data capture system at www.cliresdms.org. If your site would like host electronic data on an isolated server, we are happy to support the establishment of locally hosted databases.
- Please contact us at isaric@oucru.org if we can help with databases, if you have comments and to let us know that you are using the forms.

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

DEMOGRAPHIC - DEMO

Date of assessment [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Clinic visited ☐Survivor clinic ☐Eye-care clinic ☐ENT clinic ☐General clinic ☐Other, specify: _____

Type of visit to the clinic ☐First/baseline visit ☐Follow-up visit

If First/baseline visit, complete the sections below or review the available information

How was the patient referred to this clinic? ☐Self-referral ☐Community outreach referral

Last name / surname _____ First name _____

Laboratory ID (VHF number)(i.e. PLK number) _____ ☐N/A

Estimated age [___][___][___] years OR (if <2 years) [___][___] months Sex: ☐Male ☐Female

OR Date of birth *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Language spoken (choose 1-2 primary) [Drop down list] Other, specify _____

[Drop down list] Other, specify _____

Country: ☐Sierra Leone ☐Guinea ☐Liberia ☐Other [Drop down – standard with all countries]

Geographic region (primary) - District: [Drop down according to country] or _____

Geographic region (secondary) - Chiefdom [Drop down according to district] or _____

Address (town/village, road) in detail _____

Tel (primary contact number) _____

Tel (secondary contact number) _____ Name of phone owner/family member _____

Married ☐Yes ☐No

Patient's living situation ☐Lives alone ☐Lives with family ☐Lives with people other than family

EVD POST-INFECTION DATA MODULES

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

EBOLA HISTORY - EVDHIST

Treated in an ETC/ETU ☐NO ☐YES ☐N/A

If YES, ETC/ETU Country ☐Guinea ☐Sierra Leone ☐Liberia ☐Other[List–standard with all countries] ☐N/A

ETC/ETU District Drop down according to country ☐N/A

ETC/ETU Name _____ ☐N/A

Patient identification number in ETU/ETC _____ ☐N/A

Earliest admission data to holding center/CCC/ETC/ETU [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A

Latest discharge date from CCC/ETC/ETU [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A

Do you want to record self reported symptoms during EVD infection ☐YES ☐NO

If Yes, mark self reported symptoms of Ebola before and/or during admission to CCC/Holding Center/ETU/ETC

History of fever	☐NO	☐YES ☐N/A	Altered consciousness /confusion	☐NO	☐YES ☐N/A
Cough	☐NO	☐YES ☐N/A	Seizures	☐NO	☐YES ☐N/A
with sputum production	☐NO	☐YES ☐N/A	Abdominal pain	☐NO	☐YES ☐N/A
bloody	☐NO	☐YES ☐N/A	Vomiting	☐NO	☐YES ☐N/A
Sputum/haemoptysis	☐NO	☐YES ☐N/A	Nausea	☐NO	☐YES ☐N/A
Sore throat	☐NO	☐YES ☐N/A	Diarrhoea	☐NO	☐YES ☐N/A
Runny nose (rhinorrhoea)	☐NO	☐YES ☐N/A	Conjunctivitis	☐NO	☐YES ☐N/A
Ear ache	☐NO	☐YES ☐N/A	Skin rash	☐NO	☐YES ☐N/A
Wheezing	☐NO	☐YES ☐N/A	Skin ulcers	☐NO	☐YES ☐N/A
Chest pain	☐NO	☐YES ☐N/A	Lymphadenopathy	☐NO	☐YES ☐N/A
Joint or muscle pain/aches	☐NO	☐YES ☐N/A	Bleeding	☐NO	☐YES ☐N/A
Intense fatigue/malaise	☐NO	☐YES ☐N/A	If bleeding, specify site(s):	_Drop down with site____	
Headache	☐NO	☐YES ☐N/A		_Drop down with sites___	
Shortness of breath	☐NO	☐YES ☐N/A		_Drop down with site____	
Lower chest wall indrawing	☐NO	☐YES ☐N/A		_Drop down with sites___	
				Other _____	

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

CO-MORBIDITIES/CLINICAL HISTORY – COMORB

Known conditions diagnosed or existing before Ebola infection ☐Click here to mark all below as NO

Chronic cardiac disease	☐NO	☐YES ☐N/A	Metastatic solid tumour	☐NO	☐YES ☐N/A
Chronic pulmonary disease (not asthma)	☐NO	☐YES ☐N/A	Any malignancy including leukaemia & lymphoma	☐NO	☐YES ☐N/A
Asthma (physician diagnosed)	☐NO	☐YES ☐N/A	AIDS / HIV	☐NO	☐YES ☐N/A
Renal disease	☐NO	☐YES ☐N/A	Obese (as defined by clinical staff)	☐NO	☐YES ☐N/A
Moderate or severe liver disease	☐NO	☐YES ☐N/A	Diabetes with chronic complications	☐NO	☐YES ☐N/A
Mild liver disease	☐NO	☐YES ☐N/A	Rheumatologic disease	☐NO	☐YES ☐N/A
Chronic neurological disease	☐NO	☐YES ☐N/A	Dementia	☐NO	☐YES ☐N/A
Hemiplegia or paraplegia	☐NO	☐YES ☐N/A	Other, Specify: _____	☐NO	☐YES ☐N/A

Has the patient ever been diagnosed with tuberculosis (TB)? ☐YES ☐NO ☐N/A

If Yes, Is the patient currently taking TB medication? ☐YES ☐NO ☐N/A

If Yes, Has the patient ever completed a course of TB treatment? ☐YES ☐NO ☐N/A

Any relevant social history _____

FEMALE REPRODUCTIVE HEALTH - FEMALEHEALTH

If male or female pre-menarche / post menopause check here to skip module ☐

Currently pregnant ☐NO ☐YES ☐Do not know or last menstrual period >4 weeks ago ☐Post-menopausal

If YES, Were you pregnant when you had Ebola ☐NO ☐YES ☐N/A

If YES, Gestation age of fetus [___][___] weeks

If NO or Do Not Know, Currently using which method(s) of contraception

O Condoms O Birth control pill O Intrauterine device (IUD) O Other, specify _____ ☐NONE ☐N/A

Currently breast-feeding ☐NO ☐YES ☐N/A

EVD POST-INFECTION DATA MODULES

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

VITAL SIGNS & SYMPTOMS - VITALnSYMP

Date of assessment: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Temperature: [___][___][___].[___]°C ☐N/A

Oxygen saturation: [___][___][___]% ☐N/A

HR: [___][___][___]beats per minute ☐N/A

RR: [___][___]breaths per minute ☐N/A

Systolic BP: [___][___][___]mmHg ☐N/A

Diastolic BP: [___][___][___]mmHg ☐N/A

Weight: *(whole number)* [__][__][__]kg ☐N/A

Height: [__][__][__]cm ☐N/A

MUAC: [__][__][__][__]mm ☐N/A

Z score: ☐+ (plus) or ☐- (minus) [__].[__] ☐N/A

Select as appropriate

☐(First/baseline visit) = Have you experienced any of the following symptoms since discharge from the ETU/ETC/CCC

☐(Follow-up visit) = Have you experienced any of the following symptoms since your last clinic visit

Any problems with your vision/eyes	☐NO ☐YES - *COMPLETE EYES MODULE* ☐N/A
Any problems with your joints, muscles or ribs/side of chest?	☐NO ☐YES - *COMPLETE JOINTS MODULE* ☐N/A
Any problems with your hearing, ringing/sounds in the ears or aural fullness (feels like ears are plugged)	☐NO ☐YES - *COMPLETE EARS MODULE* ☐ N/A
Any problems with respiratory (breathing) or cardiac systems (chest pain)	☐NO ☐YES - *COMPLETE RESPIRATORY & CARDIAC MODULE* ☐ N/A
Any psychiatric, sleep disturbance, motor, reflex or nervous system disorders	☐NO ☐YES - *COMPLETE PSYCHIATRIC & NERVOUS SYSTEM MODULE* ☐ N/A
Any GI, reproductive, renal problems	☐NO ☐YES - *COMPLETE GI, RENAL & REPRODUCTIVE MODULE* ☐ N/A
Any other problems	☐NO ☐YES *If YES, COMPLETE OTHER SYMPTOMS MODULE* ☐ N/A

MEDICATION – MEDS

Allergy to any medication ☐NO ☐YES ☐N/A If YES, specify ______________________________

Medication history, NOT including ocular medication (see EYES and EYE SPECIALIST):

Any medication before EVD infection ☐NO ☐YES ☐N/A If YES, specify ______________________

New medications started after EVD infection resolved ______________________________

Any medications (still) taken regularly now ☐NO ☐YES ☐N/A

Name of medication *(generic name preferred)*	**Amount**	**Unit**	**Frequency**	**Start date** *(DD/MM/20YY)*	**End date** (DD/MM/20YY)	**Route of administration**
	______	☐g ☐mg ☐mcg ☐IU ☐ml ☐Other__	☐Once daily (QD) ☐Twice daily(BID) ☐Thrice daily(TID) ☐Four times daily(QID) ☐Weekly ☐Unknown ☐Other___________	__/__/20__	☐On-going __/__/20__	☐IV ☐oral ☐inhaled ☐other ☐unknown
	______	☐g ☐mg ☐mcg ☐IU ☐ml ☐Other__	☐Once daily (QD) ☐Twice daily(BID) ☐Thrice daily(TID) ☐Four times daily(QID) ☐Weekly ☐Unknown ☐Other___________	__/__/20__	☐On-going __/__/20__	☐IV ☐oral ☐inhaled ☐other ☐unknown
	______	☐g ☐mg ☐mcg ☐IU ☐ml ☐Other__	☐Once daily (QD) ☐Twice daily(BID) ☐Thrice daily(TID) ☐Four times daily(QID) ☐Weekly ☐Unknown ☐Other___________	__/__/20__	☐On-going __/__/20__	☐IV ☐oral ☐inhaled ☐other ☐unknown
	______	☐g ☐mg ☐mcg ☐IU ☐ml ☐Other__	☐Once daily (QD) ☐Twice daily(BID) ☐Thrice daily(TID) ☐Four times daily(QID) ☐Weekly ☐Unknown ☐Other___________	__/__/20__	☐On-going __/__/20__	☐IV ☐oral ☐inhaled ☐other ☐unknown
	______	☐g ☐mg ☐mcg ☐IU ☐ml ☐Other__	☐Once daily (QD) ☐Twice daily(BID) ☐Thrice daily(TID) ☐Four times daily(QID) ☐Weekly ☐Unknown ☐Other___________	__/__/20__	☐On-going __/__/20__	☐IV ☐oral ☐inhaled ☐other ☐unknown

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

EYES - EYES

Date of completion [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

☐Check here if eyes are normal and all items below are NO

Blurry vision	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Dry eye	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Eye burning	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Eye foreign body sensation	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Eye pain	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Flashes of light	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Floaters	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Full loss of vision	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Itchy eye	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Light sensitivity	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Red eye	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Watery eye (tearing without crying)	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Other, specify _____	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____
Other, specify _____	☐No	☐Right eye	☐Left eye	☐Both eyes	☐N/A	Note:_____

Did first eye symptoms start before, during or after Ebola infection ☐Before ☐During(In ETU) ☐After discharge

If started before Ebola infection, how long before [___][___] ☐weeks ☐months ☐years before

If started after discharge, how long after [___][___] ☐days ☐weeks ☐months after discharge

Are the main symptoms getting better or worse from when it first started ☐Better ☐Worse ☐No change

Did you receive any eye drops for the symptoms since discharge from the ETU ☐YES ☐NO

If YES, how did the symptoms change after starting the drops ☐No change ☐Got better ☐Got worse

Did you receive any oral steroids for the symptoms since discharge from the ETU ☐YES ☐NO ☐N/A

If YES, how did the symptoms change after starting the oral steroids ☐No change ☐Got better ☐Got worse

Notes on relevant ocular history

_____

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

JOINTS - JOINTS

Date of completion [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

☐Check here if joints are normal and all items below are NO

Currently experiencing any of the following?

Abnormal appearance and/or movement of head and/or neck ☐NO ☐YES ☐N/A

Dental symptoms ☐NO ☐YES ☐N/A

Low back pain/ache ☐NO ☐YES ☐N/A

Muscle and/or Joint pain/ache ☐NO ☐YES ☐N/A

Pain with chewing ☐NO ☐YES ☐N/A

Rib or costochondral pain (point to sternum/costochondral area when asking) ☐NO ☐YES ☐N/A

Other (e.g. redness, swelling, stiffness) ☐NO ☐YES ☐N/A If YES, specify _____

Which joints are involved in current symptoms? ☐Check here if none and all items below are NO

Wrist	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Elbow	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Knuckles (MPC)	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Proximal interphalangeal (PIP)	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Distal interphalangeal (DIP)	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Shoulder	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Hip	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Knee	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Ankle	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Heel	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Jaw (TMJ)	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Costochondral	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Ribs	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Parotid	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____
Other, specify _____	☐No	☐Right	☐Left	☐Both	☐N/A	Note _____

Did the first joint symptoms start before, during, or after Ebola infection?
☐Before ☐During (In ETU) ☐After discharge ☐N/A

If started before Ebola infection, how long before infection [___][___] ☐weeks ☐months ☐years ago ☐N/A

If started after discharge, how long after [___][___] ☐days ☐weeks ☐months after discharge ☐N/A

Are symptoms worse in the morning or end of the day (check one) ☐Morning ☐End of day ☐No difference ☐N/A

Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change ☐N/A

If eye symptoms also exist, did the joint symptoms start before, at the same time, or after the eye symptoms started
☐Before eye symptoms started ☐Stated at same time ☐After eye symptoms started ☐N/A

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

EARS – EARS

Date of completion [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

☐Check here if ears are normal and all items below are NO

Cannot hear (complete loss)	☐No ☐Right only ☐Left only ☐Both ☐N/A Note _____
Hearing loss (incomplete loss)	☐No ☐Right only ☐Left only ☐Both ☐N/A Note _____
Ringing/sound in ear	☐No ☐Right only ☐Left only ☐Both ☐N/A Note _____
Aural fullness (feels like water in ears)	☐No ☐Right only ☐Left only ☐Both ☐N/A Note _____
Other, specify _____	☐No ☐Right only ☐Left only ☐Both ☐N/A Note _____

Did the first ear symptoms start before, during, or after Ebola infection?
☐Before ☐During (In ETU) ☐After discharge ☐N/A

If started before Ebola infection, how long before infection [___][___] ☐weeks ☐months ☐years ago ☐N/A

If started after discharge, how long after [___][___] ☐days ☐weeks ☐months after discharge ☐N/A

If eye symptoms also exist, did the ear symptoms start before, at the same time, or after the eye symptoms started
☐Before eye symptoms started ☐Stated at same time ☐After eye symptoms started ☐N/A

Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change ☐N/A

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

RESPIRATORY & CARDIAC - RESPnCARD

Date of completion [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

RESPIRATORY

☐Check here if Respiratory system is normal and all items below are NO/NORMAL

Difficulty breathing	☐NO ☐YES ☐N/A
Cough	☐NO ☐YES ☐N/A
Wheezing	☐NO ☐YES ☐N/A
Sneezing	☐NO ☐YES ☐N/A
Equal air entry and clear	☐NO ☐YES ☐N/A
Lungs	☐NO ☐YES ☐N/A If YES, specify _____

CARDIAC

☐Check here if Cardiac system is normal and all items below are NO/NORMAL

Heart sounds	☐Normal ☐Abnormal ☐N/A
Extra heart sounds	☐NO ☐YES ☐N/A
Murmurs	☐NO ☐YES ☐N/A If YES, describe _____
Jugular venous pressure (JVP) equivocal	☐NO ☐YES ☐N/A
Peripheral edema	☐NO ☐YES ☐N/A
Pericarditis	☐NO ☐YES ☐N/A
Chest pain	☐NO ☐YES ☐N/A
Edema or Swelling of ankles	☐NO ☐YES ☐N/A

PSYCHIATRIC & NERVOUS SYSTEM – PSYC&NERV Date of completion [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	
PSYCHIATRIC	☐Check here if Psychiatric is normal and all items below are NO
Difficulty sleeping	☐NO ☐YES ☐N/A
Hallucinations	☐NO ☐YES ☐N/A
Depression or excessive crying	☐NO ☐YES ☐N/A
Anxiety	☐NO ☐YES ☐N/A
NERVOUS SYSTEM	
Any mental impairment or symptoms ☐NO ☐YES ☐N/A	If NO, all items below will be marked NORMAL
Level of alertness	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Orientation to self, time and place	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Language	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Thought content	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Mood	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____

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PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

Any Cranial nerves impairment/symptoms ☐NO ☐YES ☐N/A	If NO, all fields below will be marked NORMAL
III (oculomotor nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
IV (trochlear nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
V (trigeminal nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
VI (abducens)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
VII (facial nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
VIII (vestibulocochlear nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
IX (glossopharyngeal nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
X (vagus nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
XI (spinal accessory nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
XII (hypoglossal nerve)	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____

Any Motor impairment or symptoms ☐NO ☐YES ☐N/A	If NO, all symptoms below will be marked NORMAL
Upper Extremity: Bulk	☐Normal ☐Abnormal ☐N/A If Abnormal ☐Right ☐Left ☐Both Describe _____
Upper Extremity: Tone	☐Normal ☐Abnormal ☐N/A If Abnormal ☐Right ☐Left ☐Both Describe _____
Upper Extremity: Strength	☐Normal ☐Abnormal ☐N/A If Abnormal ☐Right ☐Left ☐Both Describe _____
Lower Extremity: Bulk	☐Normal ☐Abnormal ☐N/A If Abnormal ☐Right ☐Left ☐Both Describe _____
Lower Extremity: Tone	☐Normal ☐Abnormal ☐N/A If Abnormal ☐Right ☐Left ☐Both Describe _____
Lower Extremity: Strength	☐Normal ☐Abnormal ☐N/A If Abnormal ☐Right ☐Left ☐Both Describe _____

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PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

Any sensory impairment or symptoms ☐NO ☐YES ☐N/A	If NO, all symptoms below will be marked NORMAL
Light Touch	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Pinprick	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Vibration	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Joint Position Sense	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Any Reflex impairment or symptoms ☐NO ☐YES ☐N/A	If NO, all symptom below will be marked NORMAL
Patellar	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Brachioradialis	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Ankle	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Any coordination impairment/symptoms ☐NO ☐YES ☐N/A	If NO, all symptom below will be marked NORMAL
Finger-Nose-Finger	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Heal-to-Shin	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Rapid Alternating Movements	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Fine Finger Movements	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____
Heal-to-Toe Walking	☐Normal ☐Abnormal ☐N/A If Abnormal, specify _____

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

Any other neurological impairment/symptoms ☐NO ☐YES ☐N/A If NO, all fields below will be marked NORMAL	
Changes in memory or thinking	☐NO ☐YES ☐N/A If YES, describe _____
Weakness or heaviness in a part of the body	☐NO ☐YES ☐N/A If YES, describe _____
New or different headaches	☐NO ☐YES ☐N/A If YES, describe _____
Cramps or twitching of muscles	☐NO ☐YES ☐N/A If YES, describe _____
Seizures	☐NO ☐YES ☐N/A If YES, describe _____
Atrophy (or shrinking) of muscles	☐NO ☐YES ☐N/A If YES, describe _____
Change in sound of voice	☐NO ☐YES ☐N/A If YES, describe _____
Feeling of numbness or coldness	☐NO ☐YES ☐N/A If YES, describe _____
Numbness or tingling of face	☐NO ☐YES ☐N/A If YES, describe _____
Sharp or shooting pains	☐NO ☐YES ☐N/A If YES, describe _____
Trouble buttoning clothes or putting on jewelry	☐NO ☐YES ☐N/A If YES, describe _____
Clumsiness	☐NO ☐YES ☐N/A If YES, describe _____
Dizziness or vertigo (room spinning)	☐NO ☐YES ☐N/A If YES, describe _____
Changes in ability to smell or taste	☐NO ☐YES ☐N/A If YES, describe _____
Difficulty with chewing or swallowing	☐NO ☐YES ☐N/A If YES, describe _____
Confusion	☐NO ☐YES ☐N/A
Photophobia	☐NO ☐YES ☐N/A
Memory loss	☐NO ☐YES ☐N/A
Irritability	☐NO ☐YES ☐N/A
Tremors	☐NO ☐YES ☐N/A
Hiccups	☐NO ☐YES ☐N/A
Movement problems	☐NO ☐YES ☐N/A
Glasgow coma score	[__][__] / 15
Gait	☐Normal ☐Abnormal ☐N/A
Muscle strength	☐Normal ☐Abnormal ☐N/A
Other neurological symptoms	☐NO ☐YES ☐N/A If YES, describe _____

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

GASTROINTESTINAL, RENAL & REPRODUCTIVE (GIRR)

Date of completion [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

GASTROINTESTINAL

☐Check here if GI is normal and all items below are NO

Abdominal pain	☐NO	☐YES	☐N/A
Abnormal or foul change in taste	☐NO	☐YES	☐N/A
Anorexia / loss of appetite / poor intake / poor weight gain	☐NO	☐YES	☐N/A
Excess hunger / voracious appetite	☐NO	☐YES	☐N/A
Diarrhea / loose stools	☐NO	☐YES	☐N/A
Dysphagia	☐NO	☐YES	☐N/A
Nausea	☐NO	☐YES	☐N/A
Vomiting	☐NO	☐YES	☐N/A

RENAL

☐Check here if Renal is normal and all items below are NO

Urinary retention	☐NO	☐YES	☐N/A
Urinary frequency	☐NO	☐YES	☐N/A

REPRODUCTIVE

☐Check here if Reproductive is normal and all items below are NO

Pain in testis	☐NO	☐YES	☐N/A
Testicular edema / scrotal swelling	☐NO	☐YES	☐N/A
Genital problem	☐NO	☐YES	☐N/A
Amenorrhea	☐NO	☐YES	☐N/A
Impotence	☐NO	☐YES	☐N/A

OTHER SYMPTOMS Date of completion [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	
SKIN	☐Check here if Skin is normal and all items below are NO
Skin rash	☐NO ☐YES ☐N/A
Itching of skin	☐NO ☐YES ☐N/A
Peeling of the skin	☐NO ☐YES ☐N/A
BLOOD AND LYMPH	☐Check here if Blood and lymph is normal and all items below are NO
Paleness	☐NO ☐YES ☐N/A
Unusual Bruising	☐NO ☐YES ☐N/A
HEPATOBILLIARY	☐Check here if Hepatobilliary is normal and all items below are NO
Jaundice	☐NO ☐YES ☐N/A
Yellowing of the eyes	☐NO ☐YES ☐N/A
ANY OTHER SYMPTOMS	☐Check here if there is No other symptoms and all items below are NO
Fever	☐NO ☐YES ☐N/A
Fatigue	☐NO ☐YES ☐N/A
Hair loss	☐NO ☐YES ☐N/A
Dry mouth	☐NO ☐YES ☐N/A
Malnutrition	☐None ☐Severe Acute (SAM) ☐Moderate Acute (MAM) ☐N/A
Feeding program for malnutrition	☐NO ☐YES ☐N/A If YES, list _____ Type of food _____ Quantity of food _____
Other, specify _____	☐NO ☐YES ☐N/A

EVD POST-INFECTION DATA MODULES

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

EYE SPECIALIST

Date of Assessment [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

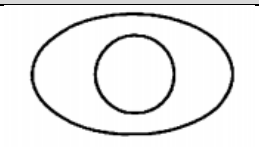
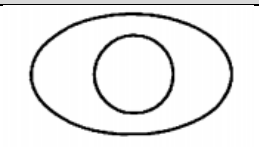
General Assessment

	Right eye (od)	Left eye (os)
Visual acuity - sc: without correction	☐N/A	☐N/A
Visual acuity - cc: with correction	☐N/A	☐N/A
Visual acuity – Pinhole (PH)	☐N/A	☐N/A
Visual acuity – PAM	☐N/A	☐N/A
Visual acuity - Manifest refraction	☐N/A	☐N/A
Intraocular pressure (IOP)	mmHg	mmHg
Extra-ocular movement (EOM)	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Confrontation visual fields (CVF)	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Pupils – Size	_____ mm ☐N/A	_____ mm ☐N/A
Pupils - Shape	☐Normal ☐Abnormal ☐N/A If Abnormal, specify: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, specify: _____
Other findings	☐Normal ☐Abnormal ☐N/A If Abnormal, specify: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, specify: _____

Slit lamp exam

Was a slit lamp exam performed? ☐NO ☐YES ☐N/A If YES, indicated findings below.

☐Check here to mark all items below as 'Normal'

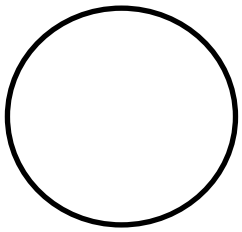
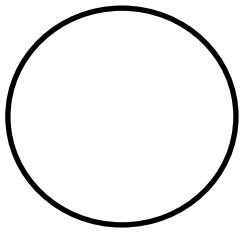
	Right Eye (OD)	Left Eye (OS)
Draw		
Orbit	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Lids	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Conjunctiva	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Cornea	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Anterior chamber **cells** SUN Grading	☐0 (<1) ☐1+ (6-15) ☐3+ (26-50) ☐0.5+ (1-5) ☐2+ (16-25) ☐4+ (>50) ☐Can not assess	☐0 (<1) ☐1+ (6-15) ☐3+ (26-50) ☐0.5+ (1-5) ☐2+ (16-25) ☐4+ (>50) ☐Can not assess
Anterior chamber **flare** SUN Grading	☐0 (None) ☐3+ (Iris/lens hazy) ☐1+ (Faint) ☐4+ (Fibrin) ☐2+ (Iris/lens hazy) ☐Can not assess	☐0 (None) ☐3+ (Iris/lens hazy) ☐1+ (Faint) ☐4+ (Fibrin) ☐2+ (Iris/lens hazy) ☐Can not assess
Iris	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Lens	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Anterior Vitreous	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____

Dilated funduscopy

Was a dilated funduscopy performed? ☐NO ☐YES ☐N/A

If Yes, indicated findings below. ☐Check here to mark all items below as 'Normal'

If Yes, was a retinal image taken? ☐NO ☐YES – If Yes, Is the image stored on the database? ☐NO ☐YES

	Right Eye (OD)	**Left Eye (OS)**
Draw		
Vitreous	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Vitreous haze (indirect) SUN Grading	☐0 (No haze) ☐0.5+ (Slight blur disk) ☐1+ (Slight disk & vessel blur) ☐2+ (Moderate disk & vessel blur) ☐3+ (Visible disk border) ☐4+ (Obscured disk) ☐N/A	☐0 (No haze) ☐0.5+ (Slight blur disk) ☐1+ (Slight disk & vessel blur) ☐2+ (Moderate disk & vessel blur) ☐3+ (Visible disk border) ☐4+ (Obscured disk) ☐N/A
Cup to Disc ratio	☐Normal ☐Abnormal ☐N/A If Abnormal, specify: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, specify: _____
Optic disc	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Macula	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Vessels	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____
Periphery	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____	☐Normal ☐Abnormal ☐N/A If Abnormal, choose from list [list] Other: _____

EVD POST-INFECTION DATA MODULES

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

Ocular diagnoses

	☐Check here to mark all items below as 'No'
Any type of uveitis?	☐No ☐Yes - Active ☐Yes - Inactive
If YES: Anterior uveitis[1]	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
If YES: Intermediate uveitis / Vitritis[2]	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
If YES: Posterior uveitis / Chorioretinitis[3]	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
If YES: Panuveitis[4]	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
Conjunctivitis	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
Scleritis / Episcleritis	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
Refractive error	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
Cataract	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
Glaucoma	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
Other (specify) _____	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes
Other (specify) _____	☐No ☐od:Right eye only ☐os:Left eye only ☐ou:Both eyes

1. Manifests in the anterior chamber and is caused by inflammation of the anterior uvea that includes the iris (iritis) and ciliary body (iridocyclitis)
2. Manifests in the vitreous with inflammation of the posterior ciliary body and pars plana (pars planitis)
3. Manifests in the posterior segment with inflammation of the retina and/or choroid
4. Involves all structures of the eye including the anterior chamber, vitreous, retina and/or choroid

Ocular Management & Treatment

Type of visit to the eye clinic: ☐First/baseline visit ☐Follow-up visit

If First/baseline visit: How was the patient referred to the eye clinic? ☐Self-referral ☐Outreach

☐Medical clinic/facility, specify name _____ ☐Other, specify _____

If Follow-up visit: How does today's eye exam compare to the nearest previous?

☐Resolved ☐Improved ☐No change ☐Worsened

Does the patient wear corrective lenses (glasses) for distance vision? ☐NO ☐YES ☐N/A

Weight _____ ☐kg or ☐lbs

Is ocular treatment needed? ☐NO ☐YES ☐N/A

If YES: What is the appropriate oral prednisone treatment:

☐Start new regimen today

☐Continue current regimen

☐Change current regimen (describe) _____

Are spectacles/corrective lenses needed? ☐NO ☐YES ☐N/A If YES, relevant details _____

Treatment – *detail all ocular treatments currently prescribed, including those started today and those given for a later start*

Treatment	Dose	Times per day	Duration (Days)	Start date (if NOT today)	Location
☐Prednisone - oral				calendar	Oral
☐Acetazolamide - oral				calendar	Oral
☐ Prednisolone acetate 1% - 5ml - drops				calendar	☐od:Right only ☐os:Left only ☐ou:Both
☐ Prednisolone sodium phosphate 0.5% - 10ml - drops				calendar	☐od:Right only ☐os:Left only ☐ou:Both
☐ Atropine sulphate 1% - 5ml - drops				calendar	☐od:Right only ☐os:Left only ☐ou:Both
☐ Timolol maleate 0.5% - 5ml - drops				calendar	☐od:Right only ☐os:Left only ☐ou:Both
☐ Brimonidine tartrate 0.2% - 5ml - drops				calendar	☐od:Right only ☐os:Left only ☐ou:Both
☐ Cyclopentolate 1% - 5ml				calendar	☐od:Right only ☐os:Left only ☐ou:Both
☐ Pilocarpine nitrate 2% - 5ml				calendar	☐od:Right only ☐os:Left only ☐ou:Both
☐ Chloramphenicol drops				calendar	☐od:Right only ☐os:Left only ☐ou:Both

EVD POST-INFECTION DATA MODULES

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

☐ Artificial Tears _____				calendar	☐od:Right only ☐os:Left only ☐ou:Both ☐op:Oral
☐ Other (specify) _____				calendar	☐od:Right only ☐os:Left only ☐ou:Both ☐op:Oral
☐ Other (specify) _____				calendar	☐od:Right only ☐os:Left only ☐ou:Both ☐op:Oral
☐ Other (specify) _____				calendar	☐od:Right only ☐os:Left only ☐ou:Both ☐op:Oral

Are oral steroids prescribed? ☐NO ☐YES ☐N/A

If YES: Is the patient currently pregnant? ☐NO ☐YES ☐N/A

If YES: Is the patient currently lactating? ☐NO ☐YES ☐N/A

If YES: Does the patient have symptoms of TB (fever/cough)? ☐NO ☐YES ☐N/A

Ocular follow-up

Eye-clinic follow-up plan

☐No follow-up necessary unless new symptoms develop

☐Follow-up in 2 weeks (include patients who received treatment for uveitis)

☐Follow-up on the following date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] or in _____ days

Name of person doing this assessment: _____

EVD POST-INFECTION DATA MODULES

PATIENT IDENTIFICATION NUMBER: [__][__][__][__][__][__]

Referral - REF

Testing services

☐HIV testing – Center/clinic name _____

☐Malaria testing – Center/clinic name _____

☐Pregnancy testing – Center/clinic name _____

☐Semen testing program – Center/clinic name _____

☐Skin snip – Center/clinic name _____

☐TB testing – Center/clinic name _____

Other services

☐Antenatal care – Center/clinic name _____

☐Child protection desk

☐HIV care – Center/clinic name _____

☐General medical – Center/clinic name _____

☐Nutrition services – Center/clinic name _____

☐Psychosocial support – Center/clinic name _____

☐Sierra Leone Association of the Blind

☐TB program – Center/clinic name _____