

Child Initials



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Outpatient Death Report – Verbal Autopsy

Date of verbal autopsy	___/___/___ <small>D D / M M / Y Y Y Y</small> <input type="checkbox"/> N/A family refused or not contactable	Date of death	___/___/___ <small>D D / M M / Y Y Y Y</small> <input type="checkbox"/> True <input type="checkbox"/> Estimated
Date research team aware of death	___/___/___ <small>D D / M M / Y Y Y Y</small>	Primary caregiver present at time of death	<input type="checkbox"/> Y <input type="checkbox"/> N
Died at home	<input type="checkbox"/> Y <input type="checkbox"/> N	Died in healthcare facility	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship of person interviewed to child	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/> N/A		

IF IT HAS NOT BEEN POSSIBLE TO COMPLETE A VERBAL AUTOPSY FOR THIS CHILD LEAVE THE REST OF THIS FORM BLANK AND COMPLETE A STUDY CONCLUSION FORM

Answer the following question based on clinical notes, and clinician verbal report:

Section 1: CHILD INJURIES AND ACCIDENTS

Verbal Autopsy	
Did the child suffer an injury or accident that led to death? <i>Select 1</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused to answer
<i>If not in notes, and clinicians cannot answer, skip to section 2: Background. CHAIN participants should have been excluded if admitted with trauma, however some may be disclosed after death.</i>	
What kind of injury or accident did the child suffer from? <i>Select all that apply</i>	<input type="checkbox"/> Road traffic crash/ injury <input type="checkbox"/> Poisoning <input type="checkbox"/> Significant fall <input type="checkbox"/> Burn/Fire <input type="checkbox"/> Drowning <input type="checkbox"/> Homicide, abuse <input type="checkbox"/> Bite or sting by venomous animal <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know <input type="checkbox"/> Other injury, specify _____
Was the injury or accident intentionally inflicted by someone else?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused to answer

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SECTION 2: BACKGROUND

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How long did the illness last?	<input type="checkbox"/> <24h ___ days ___ months <input type="checkbox"/> Don't know
How old was the deceased at the time of death?	___ months

SECTION 3: INFANT AND CHILD DEATHS

During the illness that led to death did the child have a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
How many days did the fever last?	<input type="checkbox"/> Less than 24 hours ___ days <input type="checkbox"/> Don't know
Did the fever continue until death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
How severe was the fever?	<input type="checkbox"/> Mild <38C <input type="checkbox"/> Moderate 38-39.5C <input type="checkbox"/> Severe >39.5C <input type="checkbox"/> Don't know
During the illness that led to death, did the child have more frequent loose or liquid stools than usual?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
How many stools did the child have on the day that loose or liquid stools were most frequent?	___ stools <input type="checkbox"/> Don't know
Did the frequent loose or liquid stools continue until death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
During the illness that led to death, did the child have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
For how many days did the cough last?	___ days <input type="checkbox"/> Don't know
Was the cough very severe?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
During the illness that led to death, did the child have difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
For how many days did the difficult breathing last?	___ days <input type="checkbox"/> Don't know
During the illness that led to death, did the child have fast breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
For how many days did the fast breathing last?	___ days <input type="checkbox"/> Don't know
During the illness that led to death, did he/she have indrawing of the chest?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
During the illness that led to death, did his/her breathing sound like grunting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Did the child experience any generalized convulsions or fits during the illness that led to death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Was the child unconscious during the illness that led to death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
How long before death did unconsciousness start?	<input type="checkbox"/> Less than 6 hours <input type="checkbox"/> 6-23 hours <input type="checkbox"/> 24 hours or more <input type="checkbox"/> Don't know
Did the child have a stiff neck during the illness that led to death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

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Did the child have a bulging fontanelle during the illness that led to death?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the month before he/she died, did he/she have a skin rash?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
How many days did the rash last?	___ days		Don't know
During the illness that led to death, did the child's skin flake off in patches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Did the child's hair change in color to a reddish or yellowish color?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Did the child have a protruding belly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did the child suffer from anaemia or pallor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did the child have swelling in the armpits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did the child bleed from anywhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did he/she have areas of the skin that turned black?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

SECTION 4: HEALTH RECORDS

Is the cause of death known/recorded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
What was the cause of death?	_____ <input type="checkbox"/> N/A		
Record the name and address of the hospital, health center or clinic where the care was sought:	_____		
Was a death certificate issued?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Is the death certificate available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Record the immediate cause of death from the certificate.	_____		
	<input type="checkbox"/> N/A		
Record the other underlying causes of death from the certificate.	_____		
	<input type="checkbox"/> N/A		

END

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