**DATA COLLECTION TEMPLATE
CLINICAL SNAKEBITE RESEARCH**

*There are five sections in this template. You may leave fields blank if you don’t have information. Fields marked with [\*] are part of the minimum dataset.*

**SECTION 1: Patient demographics and clinical conditions preceding snakebite**

[\*] Unique identifier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] How old are you? (record in years for patients aged 1 and above, and in months for patients less than 1 year old):

* \_\_\_\_\_\_\_\_\_\_\_ years old
* \_\_\_\_\_\_\_\_\_\_\_ months old

[\*] What is your sex?

*Select one*

* Male
* Female
* Other/prefer not to say

[\*] What is your gender?

*Select one*

* Man
* Woman
* Other/prefer not to say

What is the highest level of education you've achieved?

*Select one*

* No education
* Primary education or equivalent
* Secondary education or equivalent
* Technical education
* University education or equivalent

[\*] What is your country of origin (where the snakebite occurred)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] What is your state or district of origin (where the snakebite occurred)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your town or city of origin (where the snakebite occurred)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What best describes your ethnicity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What best describes your place of residence?

*Select one*

* Urban
* Rural
* Peri-urban (mix of urban and rural)

[\*] What pre-existing comorbidities/health conditions do you have? (Hypertension, diabetes, chronic kidney disease, history of bleeding disorder, HIV, or other)

*Select all that apply*

* Hypertension
* Diabetes
* Chronic kidney disease
* History of bleeding disorder (Haemophilia, Von Willebrand Disease, deficiency in various clotting factors, Thrombocytopenia, Disseminated Intravascular Coagulation)
* HIV
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary occupation? (Note: if the patient is a minor (< 15 years of age), please document one of the parent’s occupations here instead. We’re documenting occupation to assess financial status)

*Select one*

* Farmer
* Student
* Civil/public servant
* Artisan
* Housewife
* Labourer
* Unemployed/retired
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are working (neither unemployed nor retired), what is your employment status?

*Select one*

* Employed part-time
* Employed full-time

What is your perceived income level relative to your country of residence?

*Select one*

* Low
* Medium/average
* High

What type of flooring does your house have?

*Select one*

* Dirt
* Concrete
* Tile
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of toilet does your house have?

*Select one*

* Indoor
* Outdoor
* No toilet

What type of water source do you rely on at home?

*Select one*

* Running water
* Piped water
* Borehole
* Shallow well
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What best describes your marital status?

*Select one*

* Married/cohabiting
* Single/divorced/widowed

[\*] Are you pregnant?

*Select one*

* Yes
* No
* Unknown

Do you have health insurance?

*Select one*

* Yes
* No

----------------------- ***Description of healthcare facility/professional*** -----------------------

What is the role of the healthcare professional documenting patient information today?

*Select one*

* Nurse
* Doctor
* Student
* Intern
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years of experience does the healthcare professional have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of health facility is this?

*Select one*

* Primary
* Secondary
* Tertiary

What is this health facility's scope?

*Select one*

* Community
* District
* Regional
* National

**SECTION 2: Circumstance of snakebite**

[\*] Is this first time you have been bitten or spat on by a snake?

*Select one*

* Yes
* No

If this isn't the first time you have been bitten or spat on by a snake, how many times has it happened before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] What date were you bitten? DD/MM/YYYY \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

[\*] Approximately what time were you bitten? hh:mm (between 00:00 and 23:59) \_\_\_\_\_\_\_:\_\_\_\_\_\_\_

[\*] What time window were you bitten in?

*Select one*

* Between sunrise and noon
* Between noon and sunset
* Night time hours

[\*] What were you doing when you were bitten?

*Select one*

* Farming – planting
* Farming - tending fields between planting and harvesting
* Farming – harvesting
* Animal herding
* Sleeping
* Playing
* Walking
* Swimming
* Military training/exercises
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you wearing any protective clothing or footwear when you were bitten?

*Select one*

* Yes
* No

Did you attempt to kill or hit the snake before you were bitten?

*Select one*

* Yes
* No

[\*] What best describes the place where you were bitten?

*Select one*

* Forest or wilderness
* Farm or field
* Road
* Inside the house
* Outside the house, but within the compound or neighbourhood
* School
* Military base
* Workplace
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the snake killed?

*Select one*

* Yes
* No

If the snake died, what was the snake length (number of cm)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the distance between fang marks (number of cm)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a picture of the snake?

*Select one*

* Yes
* No

Please attach a picture of the snake:

What kind of snake do you think it was?

*Select one*

* Elapidae (cobra, krait, mamba, coral snake, death adder, tiger snake, taipan, black snake, brown snake, rinkhals)
* Viperidae (vipers, puff adder, lancehead, bushmaster, rattlesnake, moccasin, copperhead)
* Atractaspididae (asps)
* Colubridae (boomslang, keelback, twig snake)
* Unknown

Please note the exact species, if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] Where on your body were you bitten? (Upper limbs, lower limbs, trunk (back, abdomen, chest), or head, neck or eye)

*Select all that apply*

* Upper limbs
* Lower limbs
* Trunk (back, abdomen, chest)
* Head, neck, or eye

Please mark the anatomical site of snakebite on the body map anterior and posterior (circle areas that were bitten)



Was there any community support when you were bitten by the snake?

*Select one*

* Yes
* No

If yes, what kind of support?

*Select one*

* Financial
* Transportation
* Cultural (religious prayer or other traditional rituals)
* Taking care of patient's properties and some responsibilities

[\*] Did you come straight to the health facility after being bitten?

*Select one*

* Yes
* No

[\*] Is this the first health facility that you visited after being bitten?

*Select one*

* Yes
* No

[\*] If you did not come straight to this health facility after being bitten, what care was given before coming?

*Select one*

* Took painkillers or self-tied a tourniquet
* Visited traditional healer
* Referred from another health facility
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] If you visited a traditional healer, what kind of traditional treatment did you receive? (Incision, blood sucking, stone application, cupping, plant poultice, scarification, tourniquet, oral concoction, electric device, other)

*Select all that apply*

* Incision
* Blood sucking
* Stone application
* Cupping
* Plant poultice
* Scarification
* Tourniquet
* Oral concoction
* Electric device
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much did traditional treatment cost you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] How did you get to the hospital? (Walk, bicycle, motorbike, car, bus, boat, other)

*Select all that apply*

* Walk
* Bicycle
* Motorbike
* Car
* Bus
* Boat
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much did transportation to the hospital cost you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] What date did you arrive at the hospital? DD/MM/YYYY \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

[\*] What time did you arrive at the hospital? hh:mm (between 00:00 and 23:59) \_\_\_\_\_\_\_:\_\_\_\_\_\_\_

[\*] Were you admitted to the hospital?

*Select one*

* Yes
* No

**SECTION 3: Clinical characteristics of snakebite**

[\*] What type of toxicity is suspected? (Neurotoxicity, haemotoxicity, cytotoxicity, myotoxicity)

*Select all that apply*

* Neurotoxicity
* Haemotoxicity
* Cytotoxicity
* Myotoxicity

Please attach a photo of your wound at hospital admission:

[\*] In the table below,

* Specify each date that a laboratory test is done
* What are the results of the 20WBCT?
* What are the results of the PCV?
* Did the laboratory detect a bacterial infection?
* If so, what type of bacterial infection?

*All columns are part of minimum dataset except the right-most column. This data is to be documented at admission and every 24 hours after that (new row for each day). If more rows are needed, you may manually add more.*

| Date *(DD/MM/YYYY)* | Results of 20WBCT*(Normal, abnormal, or test not done)* | Results of PCV*(Normal, abnormal, or test not done)* | Did the laboratory detect a bacterial infection?*(Yes or no)* | If so, what type of bacterial infection? |
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[\*] What local symptoms are you experiencing? (Pain, swelling, bruising or ecchymosis, tingling or paraesthesia or numbness, blistering, necrosis)

*This data is to be documented at admission and every 24 hours after that (new row for each day). If more rows are needed, you may manually add more. Mark boxes with an “X” if the patient experienced that symptom. Otherwise, leave blank.*

| Date *(DD/ MM/ YYYY)* | Pain | Swelling | Bruising/ ecchymosis | Tingling/ paraesthesia/ numbness  | Blistering | Necrosis |
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[\*] What neurological systemic symptoms are you experiencing? (Muscle weakness, paralysis, dizziness, slurred speech, difficulty breathing or respiratory distress)

*This data is to be documented at admission and every 24 hours after that (new row for each day). If more rows are needed, you may manually add more. Mark boxes with an “X” if the patient experienced that symptom. Otherwise, leave blank.*

| Date *(DD/ MM/ YYYY)* | Muscle weakness | Paralysis | Dizziness | Slurred speech | Difficulty breathing/ respiratory distress |
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[\*] What haematological systemic symptoms are you experiencing? (Hypotension, bleeding from the bite site, epistaxis, gingival bleeding, bleeding from other parts of the body)

*This data is to be documented at admission and every 24 hours after that (new row for each day). If more rows are needed, you may manually add more. Mark boxes with an “X” if the patient experienced that symptom. Otherwise, leave blank.*

| Date *(DD/ MM/ YYYY)* | Hypotension | Bleeding from the bite site | Epistaxis | Gingival bleeding  | \*Bleeding from other parts of the body |
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\* Bleeding from other parts of the body (e.g. off-cycle vaginal bleeding in females, old cuts and bruises, etc.)

[\*] What renal systemic symptoms are you experiencing? (Acute kidney injury) And what general systemic symptoms are you experiencing? (Nausea or vomiting, diaphoresis or sweating, fever, shock)

*This data is to be documented at admission and every 24 hours after that (new row for each day). If more rows are needed, you may manually add more. Mark boxes with an “X” if the patient experienced that symptom. Otherwise, leave blank.*

| Date *(DD/ MM/ YYYY)* | Acute kidney injury | Nausea/ vomiting | Diaphoresis/ sweating | Fever | Shock |
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**SECTION 4: In-hospital care**

[\*] Was antivenom prescribed to you?

*Select one*

* Yes
* No

[\*] Was antivenom given to you after being prescribed?

*Select one*

* Yes
* No

[\*] What time was antivenom first administered? hh:mm (between 00:00 and 23:59) \_\_\_\_\_\_\_:\_\_\_\_\_\_\_

[\*] Antivenom administration details:

* Specify each date that antivenom was administered
* What was the name of the antivenom given to you?
* How much antivenom was given to you? (number of doses/vials)

*This data is to be documented at admission and every 24 hours after that (new row for each day). If more rows are needed, you may manually add more.*

| Date *(DD/ MM/ YYYY)* | Name of antivenom | Amount of antivenom (number of doses/vials) |
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Was the antivenom free of cost?

*Select one*

* Free
* Purchased

How much did antivenom cost you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the antivenom from the hospital stock (as opposed to purchasing externally)?

*Select one*

* Yes
* No

[\*] Did you ever experience acute allergic reaction to antivenom?

*Select one*

* Yes
* No

[\*] What was the severity of your acute allergic reaction to antivenom?

*Select one*

* Mild: skin and subcutaneous tissues only
* Moderate: features suggesting respiratory, cardiovascular, or gastrointestinal involvement
* Severe: hypoxia, hypotension, or neurologic compromise

[\*] Did you ever experience serum sickness?

*Select one*

* Yes
* No

[\*] What other supportive treatments were given? (Blood transfusions, other supportive transfusions, anti-tetanus medication, antibiotics, analgesic - NSAIDS, analgesic - non-NSAIDS, steroid, neostigmine, antiarrhythmic)

*This data is to be documented at admission and every 24 hours after that (new row for each day). If more rows are needed, you may manually add more. Mark boxes with an “X” if the patient received that treatment. Otherwise, leave blank.*

| Date *(DD/ MM/ YYYY)* | Blood transfusions | Other supportive infusions | Anti-tetanus medication | Antibiotics | Analgesic - NSAIDS | Analgesic - non-NSAIDS | Steroid | Neostigmine | Antiarrhythmic |
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How much did other supportive treatments cost you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was any psychological/social support provided to you in-hospital?

*Select one*

* Yes
* No

**SECTION 5: Complications and outcomes**

Were you admitted to ICU?

*Select one*

* Yes
* No

How long did you stay in ICU? (DD/MM/YYYY to DD/MM/YYYY)

\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Did you undergo mechanical ventilation?

*Select one*

* Yes
* No

How long did you undergo mechanical ventilation? (DD/MM/YYYY to DD/MM/YYYY)

\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Did you undergo dialysis?

*Select one*

* Yes
* No

Did you undergo renal replacement therapy?

*Select one*

* Yes
* No

[\*] Did you undergo surgical intervention?

*Select one*

* Yes
* No

[\*] If you underwent surgical intervention, what kind of intervention did you undergo? (Amputation, debridement, fasciotomy)

*Select all that apply*

* Amputation
* Debridement
* Fasciotomy

[\*] What was your pregnancy outcome, if applicable?

*Select one*

* Patient still pregnant at time of discharge
* Patient gave birth: no complications
* Patient gave birth: preterm birth
* Patient gave birth: miscarriage
* Patient gave birth: still birth
* Patient gave birth: neonatal death
* Not applicable (patient not pregnant)

[\*] What was the outcome of your snakebite?

*Select one*

* Discharged alive
* Died

[\*] Specify the date of the final outcome: DD/MM/YYYY \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Please attach a photo of your wound at hospital discharge:

[\*] If you were discharged alive, what type of discharge was it?

*Select one*

* Discharged with improvement
* Referred to another institution
* Absconded
* Discharged against medical advice
* Palliative discharge

[\*] If you were referred to another institution, what was the outcome there?

Select one

* Discharged with improvement
* Absconded
* Discharged against medical advice
* Palliative discharge
* Died
* Unknown

What type of support do you have access to after discharge? (social assistance, family support, community support, temporary financial support, access to social work services, no additional support)

*Select all that apply*

* Patient receiving social assistance
* Patient receiving family support
* Patient receiving community support
* Patient receiving temporary financial support
* Patient has access to social work services
* Patient has no additional support

What long-term complications are you facing 30 days after discharge? (Blindness, limb loss, psychological impairment, other mental health impacts)

*Select all that apply*

* Blindness
* Limb loss
* Psychological impairment
* Other mental health impacts
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach a photo of your wound at the 30-day follow up:

Was the care you received satisfactory?

*Select one*

* Yes
* No