**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 your country of origin (where the snakebite occurred)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

[\*] 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] Are you pregnant?

*Select one*

* Yes
* No
* Unknown

**SECTION 2: Circumstance of snakebite**

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

*Select one*

* Yes
* No

[\*] 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] 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

[\*] 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 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[\*] 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

[\*] 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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[\*] 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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**SECTION 5: Complications and outcomes**

[\*] 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 \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

[\*] 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