CASE INVESTIGATION FORM

Governorate/Province: Dis	strict/Area:
Town/Village/Settlement/Camp:	
Health Facility: Age	ency:
Date://	
Name of reporting officer:	
1. PATIENT IDENTIFICATION	
Case No: Name :	
Location:	
Date of birth: / / Age :	Sex: M F
2. CLINICAL DATA	
Date of onset of illness: / /	
Acute watery diarrhoea	
Bloody diarrhoea	
□ Fever	
□ Rash	
Cough	
Vomiting	
Neck stiffness	
Muscle weakness	
Increased secretions (eg. sweating, drooling)	
Other:	
3. LABORATORY DATA	
Sample: Date taken: / /	Lab. received:/ /
Name of Laboratory:	
Type of test: Date of results: _/ /	_ Result: Pos. Neg.
4. FINAL CLASSIFICATION	
Confirmed: Laboratory Da Clinical case	ate of final diagnosis: / /
Dis	scarded final diagnosis:
5. FIELD INVESTIGATOR	
Name:	
	gnature:

NOTE: ONE FORM PER CASE INVESTIGATED

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