26	Final Classification (Not a case, Suspect, Probable, Confirmed by Lab, Confirmed by epidemiological link,Pending)	
27	Other Notes and Observations	
28	Date latest update of this record (dd/mm/yyyy)	
Area: Risk factor search (Information to be obtained from the water and sanitation group of theinvestigation team)		
	Variables/Questions	**Answers**
	Mapping Potential Hazards	
1	**Potential vibrio vehicles: drinking water**	
2	Drinking water source 1	
3	Drinking water source 2	
4	Drinking water source 3	
5	Drinking water source 4	
6	**Potential vibrio vehicles: non drinking water**	
7	Non drinking water source 1	
8	Non drinking water source 2	
9	Non drinking water source 3	
10	Non drinking water source 4	
11	**Potential vibrio vehicles: Food items**	
12	Food items 1	
13	Food items 2	
14	Food items 3	
15	Food items 4	
	Food items 5	
17	Food items 6	
18	Food items 7	
19	Food items 8	
20	**Bacteriology lab findings**	
21	Drinking water foundcontaminated by vibrio	
22	Non drinking water found contaminated by vibrio	
23	Food items found contaminated by vibrio	
24	**Looking out for Exposure to the identified hazards**	
25	Water used by the patient for drinking : (list by type, e.g.tap water, Borehole, unprotected well, protected well, River, dum, lake, pond):	
26	Within 3 days prior to the onset of the disease did thepatient drink from	
27	Water source 2 (Yes/No)	

28	Water source 3 (Yes/No)	
29	Water source 4 (Yes/No)	
30	Water source 5 (Yes/No)	
31	Within 3 days prior to the onset of the disease did the patient eat	
32	Food item 1 (Yes/No)	
33	Food item 2 (Yes/No)	
34	Food item 3 (Yes/No)	
35	Food item 4 (Yes/No)	
36	Food item 5 (Yes/No)	
	Travel to a high risk area	
37	Within 3 days prior to the onset of the disease did thepatient attend any	
38	Funerals (Yes/No)	
39	Other social event (Yes/No)	

GW F1

KENYA GUINEA WORM ERADICATION PROGRAMME
CASE INVESTIGATION FORM FOR GUINEA WORM DISEASE

Reporting Information

Village: Division: Sub-county:
Reporting Health Facility: Reporting Officer: Designation: Date:

Details of investigation

S/No	Patient Name	Age	Sex	Place of residence *(Leave this blank if the place of residence is the same as the place of reporting)*		Date rumour Reported	Reported By	Date Rumour Investigated	Investigated By	Outcome *(Confirmed GW case/ Pending/ Discarded)*	Date of Emergence of first GW	Cross Notification *(Done if Confirmed GW Case's place of reporting is different from place of residence)*	Epid No.
				Village	Sub-county								

*Serial number: This indicates the cumulative sequence of rumours reported since the beginning of the year.
** Epidemiological number: Is assigned by the county and is the link to the case in Form GWEP 3

Total number of rumours/suispected invesigated during the year: Total number of confirmed guinea worm case during the year:
Total number of confirmed guinea worm cases cross-notified:

Date Report Sent to Sub-county level: Date Rep[ort Received at the Sub-county Level:
Sent By: Received By:

KENYA GUINEA WORM ERADICATION PROGRAMME
CASE INVESTIGATION FORM FOR GUINEA WORM DISEASE

To be completed in triplicate **Epid No:**_ _ _-_ _ _-_ _ _-_ _-_ _ _ _

I. Reporting/Investigation Information

Reporting Village:_____ Sub-county:_____ County:_____

Date Case Reported: (dd/mm/yyyy)_____/___/_____ Reported by:_____ Position:_____

Date Case Investigated:_____/___/_____ Investigated by:_____ Position:_____

II. Patient Information and Place of Residence

Name:_____ Father's Name/Landlord's Name:_____

Age:_____ Sex:_____ Occupation:_____

Resident Address: Village:_____ Zone:_____

Area/Sub Sub-county:_____ Sub-county:_____ Region/County_____

Setting: Urban/Rural_____ Land Marks:_____

Phone number _____

Place of residence is same as the reporting village: YES/NO Residence since when(in months):_____

(Please fill BOX "III. Place stayed in the last 10-14 months …." if the number of months stayed in this box was less than 10.)

III. Place stayed in the last 10-14 months if not the same as above.

Village:_____ Zone:_____ Area/Sub Sub-county:_____

Sub-county:_____ Region:_____ Country:_____

IV. Travel History of patient in the last 10-14 months

Date From:	Date To:	Village:	Sub Sub-county	Sub-county:	Region:

Possible water sources that the patient might have contaminated with location details and GPS:if available

Name	Lattitude	Longitude	Type	Source	Check box if Treated with Abate and Date
					☐ _____
					☐ _____
					☐ _____
					☐ _____

V. Sign and symptom

What was the first sign/symptom before the emergence of worm? Blister/Itching/Swelling/Others, Specify_____

Emergence of guinea worm: YES/NO No of Worms:_____ Is this the first guinea worm emerged this year? YES/NO

KENYA GUINEA WORM ERADICATION PROGRAMME
CASE INVESTIGATION FORM FOR GUINEA WORM DISEASE

To be completed in triplicate **Epid No:**_ _ _-_ _ _ -_ _ _-_ _-_ _ _ _

Date of the First guinea worm emerged:_____/___/_____Was the case detected before worm emerged? YES/NO

VII. Case Containment Measures and Guinea-worm registry

Received any health education: YES/NO Patient entered any water source: YES/NO

Place Managed: CCC/Home/Health Centers/Hospital

Name of Health Facility/Health Center/Other Centers if patient was hospitalized:____ Admission Date:

_____/____/_____` Discharged Date:_____/____/_____

SN.NO.	Location of worm	Date worm detected	Date guinea-worm Extracted/emerged	Date confirmed by supervisor:	Date guinea-worm completely expelled
_____	_____	___/____/_____	___/____/_____	___/____/_____	___/____/_____
_____	_____	___/____/_____	___/____/_____	___/____/_____	___/____/_____
_____	_____	___/____/_____	___/____/_____	___/____/_____	___/____/_____
_____	_____	___/____/_____	___/____/_____	___/____/_____	___/____/_____
_____	_____	___/____/_____	___/____/_____	___/____/_____	___/____/_____
_____	_____	___/____/_____	___/____/_____	___/____/_____	___/____/_____
	_____	___/____/_____	___/____/_____	___/____/_____	___/____/_____
_____					

VIII. Specimen Handling

Was a specimen (worm) saved and preserved in alcohol? YES/NO If NO WHY?

Date sent to Region:_____Received By:_____Date Received:_____

Date sent to National:_____Received By:_____Date Received:_____

For National Secretariat Only:

Did you send it for confirmation? Yes/No Date sent:_____Sent To:_____

Date Result Received_____

Result:

IX. Other Information

Use of cloth filter: YES/NO Frequency of changing filters 1-rarely; 2-sometimes; 3-always; 4-never

Remarks:_____

Person who completed this form:

_____ _____ _____ _____

NAME POSITION CELL PHONE NO SIGNATURE

c. Maternal Death Notification (MDN) Form CONFIDENTIAL *MOPHS*

For official use only						MDN Form number						

INSTRUCTIONS

1. ***This form must be completed for all deaths, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy***
2. ***Mark with a tick where applicable***
3. ***The MDN form to be filled by the most Senior Health Worker at that level, in consultation with immediate care givers***
4. ***The forms should be filled in 4 copies; the original remains in the facility, one copy sent to the Sub-county MD Committee, the Provincial MD committee and theNational MD Committee***
5. ***The form should be filled immediately after the occurrence of death (within 24 hours)***
6. ***These confidential forms should be in the custody of the Nursing Officer i/c and the Secretaries of the MDR committees***
7. ***The form should have no names, or any other identification details of the deceased***
8. ***For Coding purposes: 1=community/home, 2=dispensary, 3=Health Centre, 4=Sub-sub-county/ Sub-county hospital, 5=Provincial, 6=National/Teaching***

1. Locality where death occurred

Province		Sub-county		Level of care code ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Managing authority ☐ Public ☐ NGO/FBO ☐ Private ☐ Other, specify				

2. Details of deceased

Age yrs ☐☐	Citizenship	Para	+☐ ☐	Gravida	☐☐	Gestation (weeks) (or at delivery)	☐☐	Days since delivery/abortion	☐☐

3. Details of Admission (where death occurred)

Date of admission:							Time of admission:	Date of death:						Time of death:
Main reason for admission:							Referral from another centre?yes ☐ ☐ no ☐ unknown		If "Y" from:					Level of care code ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Stage of pregnancy on admission:							☐ Ectopic pregnancy ☐ Aborting ☐ Antepartum ☐ Intrapartum ☐ Puerperium							
Condition on admission:							☐ Stable ☐ Critically ill ☐ Dead on arrival ☐ Other, specify							

Stage of pregnancy at moment of death:	☐ Abortion ☐ Ectopic pregnancy ☐ Antepartum ☐ Intrapartum ☐ Puerperium

4. Antenatal and Delivery Care

Did she receive antenatal care? ☐ yes ☐ no ☐ unknown	If "Y"	Level of care code ☐1 ☐2 ☐3 ☐4 ☐5 ☐6	No. of visits ☐1 ☐2 ☐3 ☐4 ☐>4
Did she receive any Emergency Obstetrics Care? ☐ yes ☐ no ☐ unknown	If "Y"	Level of care code ☐2 ☐3 ☐4 ☐5 ☐6	
Delivery ☐ yes ☐ no	If "Y"	☐ SVD-skilled ☐ SVD-unskilled ☐ Vacuum ☐ CS ☐ Destructive operation ☐ Other, specify	
Baby outcome, tick	☐ Alive ☐ Fresh stillbirth ☐ Macerated stillbirth ☐ Neonatal Death		

5. Cause of death

Direct cause ☐ yes ☐ no	If "Y"	☐ Hemorrhage ☐ Infection ☐ Eclampsia ☐ Obstructed labour ☐ Abortion
Indirect cause ☐ yes ☐ no	If "Y"	☐ Malaria ☐ Anaemia ☐ HIV/AIDS ☐ Cardiovascular ☐ Other specify

6. In your opinion were any of these factors present

System	Factors
Personal / family (1st delay)	☐ Failure to recognise danger signs ☐ Ignorance of available services ☐ Delay in woman seeking help ☐ Cultural / religious reasons / objections Poverty ☐ High cost of treatment ☐ Other, specify
Access to skilled attendance (2nd delay)	☐ Lack of communication / transport from home to health care facility ☐ Lack of communication / transport between health care facilities ☐ Long distances / poor roads ☐ Refusal of treatment or admission ☐ Other, specify
Quality of care (3rd delay)	☐ Lack of skilled human resources ☐ Poor attitude ☐ Low morale ☐ Poor interpersonal relationship ☐ Lack of expertise ☐ Lack of skills ☐ Lack of blood for transfusion ☐ Lack of emergency/essential drugs (e.g. antibiotics, oxytocics, anticonvulsants, iv fluids) Lack of equipment or supplies ☐ Inappropriate/delayed interventions ☐ Other, specify

Case based Multi-Drug Resistant and Extensively Drug Resistant Tuberculosis Report Form

County:	**Year:**	
Quarter:	**Month:**	**Drug Susceptibility Test Results (S=sensitive; R=Resistant; I=intermediate; U=unknown)**

*** Multi-drug Resistant TB =** Resistance to at least Isoniazid and Rifampicin

****Extensively Drug Resistant TB =** MDR-TB plus: Resistance to any fluoroquinolone such as Ciprofloxacin, Oxfloxacin, etc, andResistance to at least one of the three second line injectable anti-TB drugs (Capreomycin, Kanamycin and Amikacin).

First-line drugs: H = Isoniazid R = Rifampicin E = Ethambutol Z = Pyrazinamide S = Streptomycin Th = Thioacetazone

Second-line drugs: Am=Amikacin Km=Kanamycin Cm=Capreomycin Cfx=Ciprofloxacin Ofx=Ofloxacin Lfx=LevofloxacinMfx=Moxifloxacin Gfx=Gatifloxacin Pto=Protionamide Eto=Ethionamide Cs=Cycloserine PAS=P-aminosalicylic acid

ID Case

Date of reception:___/___/___

Date of detection of the case ___/___/___

This Case was notified by *(tick off the right answer and specified)*

ϒ Mobile team, #_____ □ Health Centre _____

ϒ Hospital _____ □ Others: _____

Form filled by (first name and surname) _____

Information given by (first name and surname)_____

Family link with the patient _____

Identity of the patient

First name:_____Surname_____

Nickname _____

For the babies, son/daughter of (name of father) _____

Birth date:____/___/____Age (years)_____Sex □ M □ F

Permanent address: Head of Household (first name and surname) _____

Village/Suburb_____ Country_____GPS lat_____long _____

Nationality:_____Ethnic group _____

Profession of the patient *(tick off the right answer)*

ϒ Miner □ House wife □ Hunter/trading game meat □ Children

ϒ Pupil/ Student □ Farmers □ Health staff, details: Name of health care facility_____

Service_____qualification _____

ϒ Others _____

Status of the patient

Status of the patient at detection □ Alive □ Death

If dead, please specify date of death:_____/___/____

Place of death: □ Community, name village_____Country_____

□ Hospital, name and service_____ Country _____

Place of the funerals, name village: _____ Country_____

History of the disease

Date of onset of symptoms:__/_____/____

Name of the village where the patient got ill _____ Country_____