ESHealth34

Follow-up Assessment – second and all other subsequent visits

NAME

DOB

PATIENT ID NUMBER: [__][__][__][__][__][__][__][__]

NURSE LED ASSESSMENT

Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]

Date of Assessment: __/__/____
Clinic visited: _____

No. of follow-up visit (e.g. 1st, 2nd, 3rd, etc): _____

Last name/surname: _____

First name: _____

Sex: Male ☐ Female ☐
Age: ____ DOB: __/__/____

Ebola survivor: No ☐ Yes ☐
Laboratory ID (VHF number) (i.e. PLK number): _____
Local clinic or hospital number (ETU/ETC/CCC): _____
Country: _____ District: _____

Country: _____
Region: _____
Chiefdom: _____
Address: _____
_____
Tel (primary contact): _____
Tel (secondary): _____

Married:
Yes ☐
No ☐

Patient's living condition:
Lives alone ☐
Lives with family ☐
Lives with people other than family ☐

T	P	BP	RR	Sats on	%02	Capillary Blood Glucose

Weight (kg)	Height (m)	BMI (kg/m^2)	MUAC	Z score

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PROBLEM LIST (FOLLOW-UP, NURSE LED) (All patients should have a EXAMINATION MODULE completed) **Problems from previous visit. (Tick below all those that apply)** Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]	
Problems with your joints, muscles or ribs/side of chest?	☐NO ☐YES - *COMPLETE F/U JOINTS MODULE* If YES, ☐ Improved ☐ Got worse ☐ resolved
Problems with your vision/eyes	☐NO ☐YES - *COMPLETE F/U EYES MODULE* If YES, ☐ Improved ☐ Got worse ☐ resolved
Suffering from headaches	☐NO ☐YES - *COMPLETE F/U HEADACHE & NEUROLOGY MODULE* If YES, ☐ Improved ☐ Got worse ☐ resolved
Problems with your hearing, ringing/sounds in the ears or aural fullness (feels like ears are plugged)	☐NO ☐YES - *COMPLETE F/U EARS MODULE* If YES, ☐ Improved ☐ Got worse ☐ resolved
Any of the following suggest completing the *F/U NEUROLOGY MODULE* **(HISTORY & EXAMINATION)**	
Facial weakness	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Body weakness	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Numb areas	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Problems with balance/movement	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Any of the following suggest completing the *F/U CARDIAC & RESPIRATORY MODULE*	
Chest pain	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Palpitations	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Breathing?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Any of the following suggest completing the *F/U GASTROINTESTINAL MODULE*	
Abdominal pain	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Constipation?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Diarrhoea?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Any of the following suggest completing the *F/U RENAL/UROLOGY MODULE*	
Problems in passing urine?	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Changes in urinary frequency	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Blood in urine?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Change in colour of Urine	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Women only : Any of the following suggest completing the *F/U FEMALE REPRODUCTVE HEALTH MODULE*	
Changes to menstrual cycle?	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Abnormal vaginal bleeding?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Vaginal discharge?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Pelvic pain/pain during sex?	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Men only: Any of the following suggest completing the *F/U MALE REPRODUCTVE HEALTH MODULE*	
Pain/swelling around the genitals?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
getting/maintaining an erection?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Abnormal discharge from the penis?	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Any of the following suggest completing the *F/U PSYCHIATRY MODULE*	
Sleep disturbance?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Mood changes?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Behavioural problems?	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
Anxiety problems?	☐NO ☐YES, If YES, ☐ Improved ☐ Got worse ☐ resolved
Psychosis?	☐NO ☐YES If YES, ☐ Improved ☐ Got worse ☐ resolved
OTHER	
Any further module the examining team would like filled in	

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PROBLEM LIST (FOLLOW-UP, NURSE LED) (All MODULES referred to are Follow-up Visit Modules) **All patients should have A GENERAL EXAMINATION MODULE completed. The following questions indicate if additional modules are advised.** Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]			
Problems with your joints, muscles or ribs/side of chest?	☐NO	☐YES	- *COMPLETE JOINTS MODULE*
Problems with your vision/eyes	☐NO	☐YES	- *COMPLETE EYES MODULE*
Suffering from headaches	☐NO	☐YES	- *COMPLETE HEADACHE & NEUROLOGY MODULE*
Problems with your hearing, ringing/sounds in the ears or aural fullness (feels like ears are plugged)	☐NO	☐YES	- *COMPLETE EARS MODULE*
Any of the following suggest completing the *NEUROLOGY MODULE* (HISTORY & EXAMINATION)			
Facial weakness	☐NO	☐YES	
Body weakness	☐NO	☐YES	
Numb areas	☐NO	☐YES	
Problems with balance/movement	☐NO	☐YES	
Any of the following suggest completing the *CARDIAC & RESPIRATORY MODULE*			
Chest pain	☐NO	☐YES	
Palpitations	☐NO	☐YES	
Breathing?	☐NO	☐YES	
Any of the following suggest completing the *GASTROINTESTINAL MODULE*			
Abdominal pain	☐NO	☐YES	
Constipation?	☐NO	☐YES	
Diarrhoea?	☐NO	☐YES	
Any of the following suggest completing the *RENAL/UROLOGY MODULE*			
Problems in passing urine	☐NO	☐YES	
Changes in urinary frequency	☐NO	☐YES	
Blood in urine	☐NO	☐YES	
Change in colour of Urine	☐NO	☐YES	
Women only : Any of the following suggest completing the *FEMALE REPRODUCTVE HEALTH MODULE*			
Changes to menstrual cycle?	☐NO	☐YES	
Abnormal vaginal bleeding?	☐NO	☐YES	
Vaginal discharge?	☐NO	☐YES	
Pelvic pain /pain during sex?	☐NO	☐YES	
Men only: Any of the following suggest completing the *MALE REPRODUCTVE HEALTH MODULE*			
Pain/swelling around the genitals?	☐NO	☐YES	
Problems getting/maintaining an erection?	☐NO	☐YES	
Abnormal discharge from the penis?	☐NO	☐YES	
Any of the following suggest completing the *PSYCHIATRY MODULE*			
Sleep disturbance?	☐NO	☐YES	
Mood changes?	☐NO	☐YES	
Behavioral problems?	☐NO	☐YES	
Anxiety problems?	☐NO	☐YES	
Psychosis?	☐NO	☐YES	
OTHER			
Any further module the examining team would like filled in			

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Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]

Drugs taken prior to Ebola

Indication	**Name of medication***(generic name preferred)*	**Dose =**	**Unit**	**Frequency**	**Start date** *(DD/MM/20YY)*	**End date** (DD/MM/20YY)	**End date** (DD/MM/20YY)	**Route**
					__/__/20__	☐On-going __/__/20__	☐On-going __/__/20__	
					__/__/20__	☐On-going __/__/20__	☐On-going __/__/20__	

Units

☐g
☐mg
☐mcg
☐IU
☐ml
☐Other__

Frequency

☐Once daily (QD)
☐Twice daily(BID)
☐Thrice daily(TID)
☐Four times daily(QID)
☐Weekly
☐Unknown
☐Other_____

Route

☐oral
☐IV
☐inhaled
☐other
☐unknown

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GENERAL EXAMINATION (FOLLOW-UP, DOCTOR LED)

Name of Doctor _____ Date of assessment _____

General Observation ☐ Check here if all general observation is normal and all items below are NO/NORMAL

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Jaundice	☐NO	☐YES	If YES, specify
Anaemia (pallor)	☐NO	☐YES	If YES, specify
Cyanosis	☐NO	☐YES	If YES, specify
Clubbing	☐NO	☐YES	If YES, specify
Oedema	☐NO	☐YES	If YES, specify
Lymphadenopathy	☐NO	☐YES	If YES, specify
Cardiac Exam☐Check here if all general observation is normal			
Describe if not normal			
Impression if not normal			
Respiratory Exam☐Check here if all general observation is normal			
Describe if not normal			
Impression if not normal			
Abdominal Exam☐Check here if all general observation is normal			
Describe if not normal			
Impression if not normal			
Cardiac Exam☐Check here if all general observation is normal			
Describe if not normal			
Impression if not normal			
Respiratory Exam☐Check here if all general observation is normal			
Describe if not normal			
Impression if not normal			
Abdominal Exam☐Check here if all general observation is normal			
Describe if not normal			
Impression if not normal			
Skin ☐Check here if all general observation is normal			
Rash	☐NO	☐YES	If YES, specify
Impression if not normal			
Bruising	☐NO	☐YES	If YES, specify
Impression if not normal			
Peeling Skin	☐NO	☐YES	If YES, specify
Impression if not normal			

TREATMENT THIS CONSULTATION (FOLLOW-UP, DOCTOR LED)

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Name of Doctor _____ Date of assessment _____

IMPRESSION (FOLLOW UP, DOCTOR LED

Ocular & Joint diagnoses (circle)	**Treatment (see protocol)**	**Dispensed & Patient teach back?**	**Investigations, Referral? Notes**
Uveitis	**Eye drops**	☐Dispensed & Teachback ☐Not available	
	Oral Prednisone taper as per attached protocol	☐Dispensed & Teachback ☐Not available	
	Ivermectin 200 micrograms/kg od x 2 days (if starting oral steroids)	☐Dispensed & Teachback ☐Not available	
Arthralgias (tender joints) Arthritis (tender & swollen joints)	Ibuprofen 400 mg po BID x 7 days and if no or only mild improvement after day 5, increase to 400 mg po TID x 7 days Paracetamol 500 mg po q4-6h po PRN x 14 days Costochondritis	☐Dispensed & Teachback ☐Not available	

If **Joints**, involves: ☐Single large joint ☐< 5 large joints ☐≥5 large and small joints

Other diagnoses (circle)	**Treatment (see protocol)**	**Dispensed & Patient teach back?**	**Investigations, Referral? Notes**
Costochondritis GORD (Gastro-oesophageal reflux)	Ranitidine/Omeprazole_____mg x 28 days	☐Dispensed & Teachback ☐Not available	
Presumptive anemia	Blbendazole	☐Dispensed & Teachback ☐Not available	
Oncho eradication if last received Oncho drugs >1 year ago	Ivermectin 150 micrograms/kg x 1 dose (link with NTD eradication program)	☐Dispensed & Teachback ☐Not available	
Other_____	specify _____	☐Dispensed & Teachback ☐Not available	
Other:_____	specify _____	☐Dispensed & Teachback ☐Not available	
Other_____	specify _____	☐Dispensed & Teachback ☐Not available	
Other:_____	specify _____	☐Dispensed & Teachback ☐Not available	

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PATIENT ID NUMBER: [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Name of Doctor _____ Date of assessment _____

FREE TEXT

Plan (BASELINE, DOCTOR LED)

Name of Doctor _____ Date of assessment _____

Signed_____

Print Name_____

Date _____

Contact_____