World Health Organization

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WHO Global Clinical Platform for Ebola virus disease
Data for public health response

Global Clinical Data Platform

EBOLA VIRUS DISEASE CASE REPORT FORM (CRF)

MODULE 2

INTRODUCTION

The CRF is designed to collect data obtained direct from patient examination and interview, and from review of hospital or clinical notes of people with probable or confirmed Ebola disease (caused by Zaire and Sudan species).

The CRF captures data from patients being managed as inpatients in Ebola Care Centres. Data may be collected prospectively or retrospectively. The data collection period is defined as the period from hospital admission, or first clinic visit, to discharge from care, transfer, death or continued hospitalization without possibility of continued data collection.

This CRF has three modules:

Module 1:	To be completed on the first day of presentation or admission to the Ebola Care Centre (ECC).
Module 2:	Daily Form: To be completed on inpatient days (minimum every 3 days)
Module 3:	To be completed at last visit, either hospital discharge, transfer, last outpatient follow-up or death.

GENERAL GUIDANCE

Participant identification numbers consist of a site code and a participant number.

Please email the data management team at evd_clinicaldataplatform@who.int and they will provide instructions for data entry and will assign you a 5-digit site code at that time.

EVD case report form (CRF): module 2, 29 November 2022

WHO reference number: WHO/EVD/Clinical_CRF/Module_2/2022.1

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I. CASE IDENTIFICATION and TIME OF INTERIM REVIEW

ECC number: [_____]	Site/facility name: [_____]
Date of admission: (dd/mm/yyyy) [__][__] /[__][__] / 20 [__][__]	Date of this review: (dd/mm/yyyy) [__][__] /[__][__] / 20 [__][__]

II. VITAL SIGNS AT INTERIM REVIEW – *Use the first recorded observations of the day after 06:00*

Temperature (°C): [__][__] . [__]	Heart rate (bpm): [__][__][__]	Respiratory rate (/min): [__][__]
BP (mmHg): [__][__][__] (systolic) [__][__][__] (diastolic)	O_2 saturation room air (%):[__][__][__] on ☐Room air ☐Oxygen therapy on ☐CPAP/BiPAP ☐Mechanical ventilator	Level of consciousness: A / V / P / U
Capillary refill ≥ 3 sec? ☐ Yes ☐ No		Pain score: + / ++ / +++
Passed urine in past 12 hours: ☐ Yes ☐ No	Weight (kg): [__][__][__] . [__]	Feeding: ☐ Able ☐ Unable ☐ NBM order If able, specify route: ☐ Oral ☐ feeding tube ☐ Breastfeeding
Episodes of vomiting in last 24 hours: [__][__]	Episodes of diarrhoea in last 24 hours: [__][__]	Mobility: ☐ Independent ☐ Walks with help ☐ Unable to mobilize

III. CLINICAL DETAILS AT INTERIM REVIEW

Symptoms (at time of review)

Fever	☐ Yes	☐ No	☐ Unknown
Fatigue	☐ Yes	☐ No	☐ Unknown
Weakness	☐ Yes	☐ No	☐ Unknown
Malaise	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown
Sore throat	☐ Yes	☐ No	☐Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Confusion/irritability	☐ Yes	☐ No	☐ Unknown
Back/neck pain	☐ Yes	☐ No	☐ Unknown
Joint pain	☐ Yes	☐ No	☐ Unknown
Hiccups	☐ Yes	☐ No	☐ Unknown
Chest pain	☐ Yes	☐ No	☐ Unknown
Cough	☐ Yes	☐ No	☐ Unknown
…If yes, sputum production	☐ Yes	☐ No	☐ Unknown
Difficulty breathing (shortness of breath)	☐ Yes	☐ No	☐ Unknown
Difficult/painful swallowing	☐ Yes	☐ No	☐ Unknown
Anorexia	☐ Yes	☐ No	☐ Unknown
Nausea	☐ Yes	☐ No	☐ Unknown
Abdominal pain	☐ Yes	☐ No	☐ Unknown
Diarrhoea	☐ Yes	☐ No	☐ Unknown
Vomiting	☐ Yes	☐ No	☐ Unknown
Hematemesis	☐ Yes	☐ No	☐ Unknown

Signs (at time of review)

Confusion/agitation	☐ Yes	☐ No	☐ Unknown
Seizure/convulsion	☐ Yes	☐ No	☐ Unknown
Jaundice	☐ Yes	☐ No	☐ Unknown
Rash	☐ Yes	☐ No	☐ Unknown
Pharyngeal erythema	☐ Yes	☐ No	☐ Unknown
Tender abdomen	☐ Yes	☐ No	☐ Unknown
Palpable liver/hepatomegaly	☐ Yes	☐ No	☐ Unknown
Palpable spleen/splenomegaly	☐ Yes	☐ No	☐ Unknown
Sunken eyes or fontanelle	☐ Yes	☐ No	☐ Unknown
Dehydration status	☐ None	☐ Mild	☐ Moderate
	☐ Severe	☐ Unknown	
Pressure injury to skin	☐ Yes	☐ No	☐ Unknown
Oedema, lower limb	☐ Yes	☐ No	☐ Unknown
Oedema, upper limb	☐ Yes	☐ No	☐ Unknown
Oedema, face/neck	☐ Yes	☐ No	☐ Unknown
Conjunctival injection	☐ Yes	☐ No	☐ Unknown
Bruising/petechiae	☐ Yes	☐ No	☐ Unknown
Bleeding:	☐ Yes	☐ No	☐ Unknown

If bleeding, specify:

☐ Epistaxis
☐ Mouth/gums
☐ Vaginal
☐ Hematemesis
☐ Blood in stool (melaena or PR bleeding)
☐ Hemoptysis
☐ Urine (haematuria)
☐ From IV site
☐ Other site, specify

[_____]

IV. MOST RECENT TEST RESULTS

Test	**Collection date** (dd/mm/yyyy)	**Result**
Haemoglobin (Hb)	[__][__] /[__][__] / 20 [__][__]	[__][__] . [__] g / dL
Platelets	[__][__] /[__][__] / 20 [__][__]	[__][__][__][__] x10^9 / L
Potassium (K^+)	[__][__] /[__][__] / 20 [__][__]	[__][__] . [__] mmol / L
Creatinine	[__][__] /[__][__] / 20 [__][__]	[__][__] . [__] mg / dL OR [__][__][__][__] µmol / L
Lactate	[__][__] /[__][__] / 20 [__][__]	[__][__] . [__] mmol / L
Bicarbonate (HCO_3)	[__][__] /[__][__] / 20 [__][__]	[__][__] . [__] mmol / L

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