VILLAGE CLINIC PNEUMONIA RECORDING FORM

Patient ID: __________

Section A: VILLAGE CLINIC DETAILS
District: ___________________ Health Facility: __________________________ Village Clinic: __________________________

Section B: PATIENT IDENTIFICATION DETAILS
Child’s Name: __________________ Date of birth __/__/__ Sex: Boy/Girl Diagnosis Date: __/__/__
Caregiver’s Name: __________________ Relationship: Mother/Father/Other __________
Physical Address: __________________ Village: __________________ TA: __________________

Section C: VACCINE STATUS
Tick (√) if Yes and Cross (X) if No. For PCV indicate dates of vaccine if yes

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccines</th>
<th>PCV VACCINE DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>BCG</td>
<td></td>
</tr>
<tr>
<td>6 weeks*</td>
<td>DPT-Hib+ HepB 1</td>
<td>Date__/__/____</td>
</tr>
<tr>
<td>10 weeks*</td>
<td>DPT-Hib+ HepB 2</td>
<td>Date__/__/____</td>
</tr>
<tr>
<td>14 weeks*</td>
<td>DPT-Hib+ HepB 3</td>
<td>Date__/__/____</td>
</tr>
<tr>
<td>9 months</td>
<td>Measles</td>
<td></td>
</tr>
</tbody>
</table>

Section D: SIGNS AND SYMPTOMS

Oxygen Saturation: _____% Respiratory Rate: _____ Heart Rate: _____ MUAC: _____cm Temperature _____°C

☐ Cough  ☐ Fast breathing  ☐ Chest in drawing  ☐ Convulsion  ☐ Difficult breathing  ☐ Not feeding well
☐ Palmar Pallor  ☐ Very Sleepy or Unconscious  ☐ Swelling of both feet  ☐ Vomiting everything  ☐ Others __________

Note: Check all that apply

Section E: TREATMENT/ PRE-REFERAL TREATMENT

☐ Refer to health facility  ☐ Treat at home

Cotrimoxazole adult tablet- 80/400

☐ Age 2 months- 12 months- ½ tablet  ☐ Age 2 months-12 months- ½ Tablet (total 5 tablets)
☐ Age 12 months-5 years- 1 tablet  ☐ Age 12 months-5 years- 1 tablet (total 10 tablets)

Section F: FOLLOW-UP FEEDBACK

☐ Baby Alive  ☐ Baby died  Date:__/__/____ at Health Facility/ Home/ Others (Specify): __________
☐ Follow up  ☑ Feedback done on:__/__/____

Comments: ____________________________________________________________

Compiled By (HSA Name) ___________________________ Date: __/__/____
Verified By (SHSA Name): ___________________________ Date: __/__/____

Thursday, March 14, 2013

PCV Vaccine data collection form (V5-Final)
# Pneumonia Health Centre Recording Form

**Name:**

**Address:**

**Village:**

**TA:**

**Age (months):**

**Sex (M/F):**

**Number of days of signs/symptoms:**

- [ ] More than 21 days
- [ ] Less than 21 days

**Antibiotic treatment prior to coming to health centre**

- [ ] Yes
- [ ] No
- [ ] Self referral
- [ ] Referral from village clinic

**Weight kg:**

**MUAC cm:**

**Temperature °C:**

**Respiratory rate per minute:**

**Oxygen Saturation:**

**Heart Rate per minute:**

### Clinical Features

<table>
<thead>
<tr>
<th>CHILD 2 MONTHS TO 5 YEARS</th>
<th>Classification</th>
<th>Referral Decision</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest in-drawing</td>
<td>Yes [ ] No [ ]</td>
<td>Very severe pneumonia [ ]</td>
<td>Prepare for referral [ ]</td>
</tr>
<tr>
<td>Grunting</td>
<td>Yes [ ] No [ ]</td>
<td>Severe pneumonia [ ]</td>
<td>Prepare for referral [ ]</td>
</tr>
<tr>
<td>Nasal flaring</td>
<td>Yes [ ] No [ ]</td>
<td>Pneumonia [ ]</td>
<td>Treat at home [ ]</td>
</tr>
<tr>
<td>Head nodding</td>
<td>Yes [ ] No [ ]</td>
<td>PCP [ ]</td>
<td>Prepare for referral [ ] and</td>
</tr>
<tr>
<td>Central cyanosis</td>
<td>Yes [ ] No [ ]</td>
<td>Other (specify) [ ]</td>
<td></td>
</tr>
<tr>
<td>Sleepy/difficult to wake</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not able to breastfeed</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not able to drink</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stridor in calm child</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheeze</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Young Infant < 2 Months

<table>
<thead>
<tr>
<th>Classification</th>
<th>Referral Decision</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very severe pneumonia</td>
<td>Prepare for referral</td>
<td>Benzyalpenicillin 50,000 IU/kg/dose</td>
</tr>
<tr>
<td>Severe pneumonia</td>
<td>Prepare for referral</td>
<td>Benzyalpenicillin 50,000 IU/kg/dose</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Treat at home</td>
<td>Cotrimoxazole 12 months to 5 years (10 tabs) or</td>
</tr>
<tr>
<td>PCP</td>
<td>Prepare for referral</td>
<td>Benzyalpenicillin 50,000 IU/kg/dose and Cotrimoxazole ½ tab</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HIV Status

- [ ] Positive
- [ ] Negative
- [ ] Exposed
- [ ] Unknown
- [ ] Measles at this visit or in past 2 months
- [ ] Yes
- [ ] No

### Blood film (malaria)

- [ ] Positive
- [ ] Negative
- [ ] Unknown
- [ ] Measles at this visit or in past 2 months
- [ ] Yes
- [ ] No

### Measles

- [ ] Yes
- [ ] No

### Severe Malnutrition

- [ ] Yes
- [ ] No

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**Healthcare provider name:**

**Address:**

**Village:**

**TA:**

**Previous pneumonia in the last 12 months**

- [ ] Yes
- [ ] No

**Previous hospital admissions for pneumonia in last 12 months**

- [ ] Yes
- [ ] No

**BCG:**

- [ ] No
- [ ] Yes

**PCV:**

- [ ] No
- [ ] Yes
- [ ] # Doses:

**Polio:**

- [ ] No
- [ ] Yes
- [ ] # Doses:

**DTP-HepB-Hib:**

- [ ] No
- [ ] Yes
- [ ] # Doses:

**HIV status:**

- [ ] Positive
- [ ] Negative
- [ ] Exposed
- [ ] Unknown

**Blood film (malaria):**

- [ ] Positive
- [ ] Negative
- [ ] Unknown

**Measles at this visit or in past 2 months:**

- [ ] Yes
- [ ] No

**Severe malnutrition:**

- [ ] Yes
- [ ] No

---
# PNEUMONIA INPATIENT RECORDING FORM

## Clinical features

<table>
<thead>
<tr>
<th>CHILD 2 MONTHS TO 5 YEARS</th>
<th>Classification</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest in-drawing</td>
<td>Very severe pneumonia</td>
<td>Antibiotic</td>
</tr>
<tr>
<td>Grunting</td>
<td></td>
<td>Dose</td>
</tr>
<tr>
<td>Nasal flaring</td>
<td>Severe pneumonia</td>
<td>Day 1</td>
</tr>
<tr>
<td>Head nodding</td>
<td></td>
<td>Day 2</td>
</tr>
<tr>
<td>Central cyanosis</td>
<td>Pneumonia</td>
<td>Day 3</td>
</tr>
<tr>
<td>Sleepy/difficult to wake</td>
<td></td>
<td>Day 4</td>
</tr>
<tr>
<td>Convulsions</td>
<td></td>
<td>Day 5</td>
</tr>
<tr>
<td>Not able to breastfeed</td>
<td></td>
<td>Day 6</td>
</tr>
<tr>
<td>Not able to drink</td>
<td></td>
<td>Day 7</td>
</tr>
<tr>
<td>Stridor in calm child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheeze</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YOUNG INFANT &lt; 2 MONTHS</th>
<th>Very severe pneumonia/disease</th>
<th>Antibiotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest in-drawing</td>
<td></td>
<td>Gentamicin</td>
</tr>
<tr>
<td>Grunting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal flaring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head nodding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central cyanosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleepy/difficult to wake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not feeding well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheeze</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stridor (calm child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apnoeic spells</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Antibiotics

- **Benzylicillin**
- **Amoxycillin**
- **Chloramphenicol**
- **Cotrimoxazole**
- **Other antibiotic (specify)**
- **Other treatment Oxygen**

### Treatment

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Dose</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzylicillin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Amoxycillin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cotrimoxazole</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other antibiotic (specify)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other treatment Oxygen</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HIV status

- Positive
- Negative
- Exposed
- Unknown

### Blood film (malaria)

- Positive
- Negative
- Unknown

### Measles at this visit or in past 2 months

- Yes
- No

### Severe malnutrition *

- Yes
- No

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*Severe malnutrition is visible severe wasting or oedema in both feet*
Hospitalisation

Duration of hospitalisation in either ____________________ Hours ____________________ Days

Admission diagnosis ____________________ Discharge diagnosis ____________________

Discharge and Follow-up

Course of antibiotics to be completed at home

Yes □ No □  Child returned for follow-up visit  Yes □ No □
Course of antibiotic completed**  Yes □ No □
Child fully recovered**  Yes □ No □

Mother informed to return with child once antibiotics completed

Yes □ No □

Course of antibiotic completed**  Yes □ No □
Child fully recovered**  Yes □ No □

Treatment Results

Treatment completed(1) □ Failure at 48 hrs (2) □ Failure at Day 5 □
Left against advise(3) □ Transferred (4) □ Outcome unknown (5) □

Died within 24 hours of admission □ Died after 24 hours of admission □ (See below for definitions)

Additional Remarks:

Rationale for Information/Recording System

When the decision is reached that the child has pneumonia and requires hospitalisation then the “Pneumonia Inpatient Recording Form” must be completed in addition to other forms that may be used, such as critical care pathways. The use of this form is a prerequisite of the Project providing the drugs for treatment of such cases. The form is initiated when the patient is started on treatment and is completed on discharge. The form is provided to assist the health worker in providing good quality care for the patient. All information is transferred to the Pneumonia Inpatient Register.

* If NO then tick Outcome Unknown (5) in Treatment Results section
** If YES then child can be registered as Treatment Completed(1) in Treatment Results section
1. Course of antibiotics completed and child fully recovered
2. Treatment failure means: Worsening of fast breathing, or Worsening of chest in-drawing, or Development/persistence of abnormal sleepiness or difficulty in awakening, or development/persistence of inability to drink or poor breastfeeding.
3. Child removed from the hospital against medical advise before treatment is completed
4. Child is referred for treatment to another health facility and the result of treatment is unknown; where the result is known, that result should be recorded in place of the result “transferred
5. When mother does not return with child for follow-up visit once course of antibiotic(s) is finished