FORM 10: CLINICAL OBSERVATION

Prov. ID: ☐☐ Dist. ID: ☐☐ Clinic ID: ☐☐ Health worker ID: ☐☐

Province:…….. District:……. Clinic: ……. Surveyor: ……

Interview date: …./…../ 2015	**Time** *(for every patient entry-exit to/from the clinic)*	**Start** *(hh:mm)*	1 …….:…… 2 …….:…… 3 …….:……	**End** *(hh:mm)*	1 …….:…… 2 …….:…… 3 …….:……

I. BACKGROUND INFO (Circle a number)

1. Patient		**2. Age**		**3.Sex**	
	New ……. 1		Below 6 years of age 1		Male …….. 1
	Revisit ……... 2		Children/Adolescents (6-18 years of age) …….. 2		Female 2
	Don't know …… 3		Adults (19-45 years) …… 3		
			Older age (>45 years) …… 4		

II. SYMPTOMATIC PATIENTS (Mark X if observed or heard of)

1. Fever	**2. Cough**	**3.Cảm**	**4. Diarrhea**	**5. Pain**	**6. Site of pain**	**7. Weak/Tired**	**8. Other symptoms**	**9. Days in care**
☐	☐	☐	☐	☐	…… …… …… …… ……	☐	…… …… …… …… ……	1. ……... 2. Don't know

III. Questions on history	Fever	Vomiting	Stool	Count the questions the doctor asked patients	Sputum	Fever	Chest pain	**Total questions**
								……..
	Diarrhea				**Cough/fever/cold**			

IV. Physical examination:	Yes …… 1 No …….. 2

V. How was physical examination conducted (1=Yes; 2= No; 3=Don't know) – Circle a number

1. Stethoscope	**2. Sphygmomanometer**	**3. Fever check** 3a. Manually	3b. Thermometer	**4. Touch**	**5. Taking pulse**	**6. Others**
1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

VI. INFORMATION ON PHYSICIANS' INDICATIONS

1. Drug name, dosage	**Dosage form** 1. Pill 2. Vial 3. Sachet 4. Bottle 5. Others: ……	**2. Dosing** Quantity (in the smallest dosage form)	Administrations per day	Days day of	**3. Injection** (Mark X if yes) Prescribed by doctors	Recommended by doctors	Disinfected	**4. IV** (Mark X if yes) Prescribed by doctors	Recommended by doctors	Disinfected
1……					☐	☐	☐	☐	☐	☐
2……										
3……					**5. Other instructions** (if any)					
4……					1……					
5……					2……					
6……					3……..					

6. Testing	**7. In-situ care**	**8. Provision of user guide**	**9. Counseling**	**10. Revisit appointment** *(next*	**11. Hospitalization/**

				materials *(handwritten acceptable)*				*check-in/in case of abnormality)*		**Specialist care/ Referral**	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	2	1	2	1	2	1	2	1	2	1	2

VII. TOTAL COSTS

(Input 0 if the patient does not have to pay the medical cost)

Amount.: (VND) ……. …….

MÃ BỆNH NHÂN
