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

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

| **1. Fever** | **2. Cough** | **3. Cold** | **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** | | **4. Touch** | **5. Taking pulse** | **6. Others** |
|---|---|---|---|---|---|---|
| | | 3a. Manually | 3b. Thermometer | | | |
| 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** | | | **3. Injection** (Mark X if yes) | | | **4. IV** (Mark X if yes) | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Quantity (in the smallest dosage form) | Administrations per day | Days | Prescribed by doctors | Recommended by doctors | Disinfected | 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 materials** *(handwritten* | **9. Counseling** | **10. Revisit appointment** *(next check-in/in case of abnormality)* | **11. Hospitalization/ Specialist care/ Referral** |
|---|---|---|---|---|---|

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | *acceptable)* | | | | | | | |
| 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)* ……. ……..

**PATIENT ID**