CASE REPORT FORM (CRF)

Enrolment and Demographics

Record ID _____

MR Number _____

Last Name _____

First Name _____

Address _____

Date of Birth _____
(Use the calendar or DAY-MONTH-YEAR)

Age (if no age, adult) _____

Sex Male ◯ Female ◯

Date of EMD Care _____
(Use the calendar or DAY-MONTH-YEAR)

Time of EMD Care _____

Patient phone number _____

Relative phone number _____

Marital status

◯ Single

◯ Married

◯ Divorced

◯ Widowed

Name of the referring facility _____

Level of referring facility

◯ Dispensary

◯ Health center

◯ District Hospital

◯ Regional hospital

◯ Police hospital

◯ Military hospital

◯ Private hospital

◯ Private clinic

◯ Reason for referral_____

Chief Complaint # 1 _____

Chief Complaint # 2 _____

Chief Complaint # 3 _____

Mechanism of Injury _____

Chief Complaint Category

◯ Assault (Any complaint described as an assault)

◯ Limb Injury (any injury of legs or arms or toes or Fingers or other unspecified)

◯ Wound (any complaint of wounds including Lacerations or cut)

◯ Stab wound (Any complaint of stab wound)

◯ MVC (Any injury from motor vehicle crash)

◯ Fall (any complaint of injury from fall)

◯ Animal Bite (any complaint of animal bite)

◯ Burn (Any complaint of burn injury)

◯ Head Injury

◯ GSW (Any complaint of gunshot wound)
Miscellaneous injury (all other unclassified injury

MOI category

◯ Car/Truck- driver

◯ Car/Truck- passenger

◯ Car/Truck- unknown position

◯ Pedestrian struck by car/truck

◯ Motorcycle- driver

◯ Motorcycle- passenger

◯ Motorcycle- unknown position

◯ Pedestrian struck by motorcycle

◯ Daladala-driver

◯ Daladala-passenger

◯ Pedestrian struck by Daladala

◯ Bajaj- driver

◯ Bajaj- passenger

◯ Pedestrian struck by bajaj

◯ Long distance bus- driver

◯ Long distance bus- passenger

◯ Pedestrian hit by long distance bus

◯ Other blunt injury

◯ Knife wound

◯ Gunshot wound

◯ Other penetrating injury

◯ Fall

◯ Unknown

◯ Burn

◯ Bicycle/ pedal cycle

◯ Pedestrian struck by train

◯ Other

Other, description _____

Date of Injury _____
(Use the calendar or DAY-MONTH-YEAR)

Time of injury _____

Motive of Injury

◯ Intentional ◯ Unintentional

◯ Unknown

Alcohol use Confirmed by patient

◯ Confirmed by alcohol test ◯ Suspected by care provider

◯ Suspected or reported by relative/accompanying person ◯ Unknown

Vitals

SBP _____ DBP_____

PULSE _____ RR_____

SPO2 (RA) _____ TEMP_____

Total GCS at EMD_____

Initial pain assessment and documentation at Triage

YES ◯ **NO** ◯

Physician pain assessment and documentation at treatment/ Resuscitation

YES ◯ **NO** ◯

Consent; YES ◯ **NO** ◯

Pain Assessment

How much is your pain in a scale of 1 to 10?

(1 being no pain, 10 being worst possible pain)_____

Pain Medications

Given YES ◯ **NO** ◯

Time Given_____

Type of pain medications

◯ NSAIDS

◯ Acetaminophen

◯ Opioids

◯ Other
Other medications _____

Route of administration of pain medications

◯ IM

◯ IV

◯ Oral

◯ Other

Other route _____

Diagnosis

EMD Diagnosis 1 _____

EMD Diagnosis 2 _____

EMD Diagnosis 3_____

EMD Diagnosis 4 _____

Disposition

◯ EMD Disposition Home

◯ MNH Ward

◯ MNH HDU

◯ MNH ICU

◯ Transfer to MOI

◯ Transfer to other

Appendix IV: Numerical rating scale