**APPENDIX 1:**

**NEW PATIENT FORM (To be kept in patient file at the clinic)**

**Name of health facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| 1. **SOCIO-DEMOGRAPHIC INFORMATION**
 |
| Name: |  |
| Sex: |  |
| Age: |  |
| Level of Education: |  |
| Profession: |  |
| Address and Phone number: |  |
| Name and telephone number of corresponding CHW:  |  |
| 1. **SEIZURE-RELATED HISTORY**
 |
| Age at First seizure without fever: |  |
| Date of last seizure without fever: |  |
| Description of seizure:* Brief loss of consciousness
* Jerky movements of limb(s)
* Loss of urine
* Drooling (saliva/foam)
* Brief abnormal sensations
* Head nodding movements
* Others:
 |  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No if Yes: Hearing? Vision? Smell?  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Seizure frequency (for each type)(per day/month/year): |  |
| Past Antiepileptic treatment: | *(name, dosage, daily intake)* |
| Present antiepileptic treatment: | *(name, dosage, daily intake)* |
| Birth conditions |  Normal Difficult Caesarean sectionDescribe if abnormal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Convulsion with fever?  |  Yes No if Yes, at what age?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Previous neurological condition? |  None Cerebral malaria Encephalitis/meningitis  Head trauma Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Family member(s) with epilepsy? |  Yes No if Yes, precise:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Other relevant medical history |  |
| 1. **ONCHOCERCIASIS-RELATED HISTORY**
 |
| Previous ivermectin intake: | *(number of times, last year taken)* |
| Frequent itching: |  Yes No  |
| Blurred vision: |  Yes No  |
| 1. **PHYSICAL EXAMINATION**
 |
| Parameters: | **Temperature:**\_\_\_\_\_°C **Weight:** \_\_\_\_\_Kg **Height**:\_\_\_\_\_m**Blood Pressure**:\_\_\_\_\_\_\_\_mmHg **Other**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| General state: |  Normal Moderately altered Poor  If abnormal, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Examination:* Traumatic lesions
* Burns or scars of burns
* Leopard skin
* Other skin abnormalities
* Onchocercal nodules
* Neurological examination:
 |  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No if Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal Mental disorder Muscle weaknessIf abnormal, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other relevant physical findings |  |
| 1. **QUALITY OF LIFE**
 |
| Ability to perform at school or work at a job? |  Normal Moderately affected Unable  If abnormal, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ability to work at home or in the farm? |  Normal Moderately affected Unable  If abnormal, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How would you rate your quality of life? |  Very poor Poor Neither poor nor good Good Very goodRemarks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other relevant findings |  |
| 1. **PARACLINICAL FINDINGS**
 |
| Skin snip |  Positive Negative If positive, microfilarial load:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| OV16 serology |  Positive Negative  |
| Malaria test |  Positive Negative  |
| EEG |  |
| Others |  |

**ANY OTHER RELEVANT INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIAGNOSIS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TREATMENT INITIATED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EPILEPSY EDUCATION DONE?**  Yes No **PATIENT REFERRED?**  Yes No

**NEXT APPOINTMENT:**

**Name and Signature of Health Personnel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APPENDIX 2: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MONTHLY FOLLOW UP FORM (To be archived in patient file at the clinic)**

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| 1. **PATIENT IDENTIFICATION**
 |
| Name: |  |
| Sex: |  |
| Age: |  |
| Address and Phone number: |  |
| Name / phone number of CHW:  |  |
| Monthly expenses due to epilepsy: | *(AED, transport, Lost days of work*) |
| Date of last medical visit |  |
| 1. **SEIZURE-RELATED INFORMATION**
 |
| Number of seizures since the last appointment: |  |
| Description of seizures: |  |
| Seizure frequency (for each type) | *(per day/month/year)* |
| Increase or decrease of seizures? |  |
| 1. **TREATMENT-RELATED INFORMATION**
 |
| Current antiepileptic treatment | *(name, dosage, daily intake)* |
| Adherence to treatment? |  Yes No (Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) If No, how many days missed? (count remaining AED):\_\_\_\_\_\_\_\_\_ |
| Any other treatment in addition to the prescription? |  Yes No if Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 1. **QUALITY OF LIFE**
 |
| Ability to perform at school or work at a job? |  Normal Moderately affected Unable  If abnormal, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ability to work at home or in the farm? |  Normal Moderately affected Unable  If abnormal, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How would you compare your current quality of life with your state during the last appointment? |  Much better Better Same Worse Much worseRemarks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other relevant findings |  |
| 1. **PHYSICAL EXAMINATION**
 |
| New traumatic lesions/burns? |  Yes No  If Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other relevant findings: |  |
| 1. **CONCLUSION AND MANAGEMENT**
 |
| Patient Evolution |  Improvement Degradation Same  If other diagnosis, precise:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Treatment |  Same Modified  Precise drug/dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Next appointment |  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred (precise):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Name and signature of Health Personnel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APPENDIX 3:**

**MONTHLY COMMUNITY HEALTH WORKER FORM (Handed to the clinic at the end of each month)**

**Name of patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_**

**Current treatment regimen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| 1. **ACTIONS CARRIED OUT BY CHW FOR THE MONTH**
 |
| Number of home visits to the family |  |
| Number of health talks delivered to the family |   |
| 1. **SEIZURE FREQUENCY AND AED INTAKE**
 |
| **Date** | **Number of seizures** | **Number of AED received** | **Number of AED remaining** | **Remarks** |
| 1 |  |  |  |  |
| 2 |   |  |  |  |
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 **Name and signature of CHW: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APPENDIX 4:**

**MONTHLY EPILEPSY CLINIC REPORT (To be archived by clinic head)**

**Health Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Month/Year:\_\_\_\_\_\_\_\_**

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| 1. **PWE CONSULTED AT THE EPILEPSY CLINIC**
 |
| **AGE GROUP** | **CASES SEEN** | **TOTAL** |
| **Male** | **Female** |
| **New cases** | **Follow-up cases** | **New cases** | **Follow-up cases** |
| < 5years |  |  |  |  |  |
| 5 – 15 years |  |  |  |  |  |
| 16 – 30 years |  |  |  |  |  |
| > 30 years  |  |  |  |  |  |
| **TOTAL** | **A=** | **B=** | **C=** | **D=** | **E=** |
| Total Number of epilepsy cases seen (E):\_\_\_\_\_\_\_\_\_\_\_Number of new cases of epilepsy (A+C):\_\_\_\_\_\_\_\_\_\_\_Number of Follow-up cases of epilepsy (B+D):\_\_\_\_\_\_\_\_\_\_\_Number of new PWE with positive skin snip or OV16 seropositivity:\_\_\_\_\_\_\_\_\_\_Number of PWE referred to specialists:\_\_\_\_\_\_\_\_\_\_\_Number of deaths among PWE:\_\_\_\_\_\_\_\_\_Other remarks: |
| 1. **CLINIC DETAILS**
 |
| Clinic staff (number/qualifications) |  |
| Number of active CHW |  |
| Number of support group sessions | *(precise days and time)* |
| Visits from specialist |  Yes No if Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 1. **ANTIEPILEPTIC DRUGS**
 |
| **Drug Name** | **Continually available? (Y/N)** | **If No, Number of days out of stock** | **Stock at start of month** | **Stock at end of month** | **Remarks** |
| PhenobarbitalDosage: |  |  |  |  |  |
| CarbamazepineDosage: |  |  |  |  |  |
| PhenytoineDosage: |  |  |  |  |  |
| ValproateDosage: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Monthly cost price of AED  |  |
| Monthly selling price of AED |   |
| Additional income for AED purchase | *(amount and source)* |
| Number of AED suppliers |  |
| Method of distribution of AED |  Home delivery by CHW PWE come to the clinic  PWE buy at dispatch points Others: |
| Difficulties or remarks on AED |  |

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| 1. **EXTERNAL CLINIC ACTIVITIES**
 |
| Number of epilepsy health talks: \_\_\_\_(in schools, market, church, etc) | *(precise venue and estimated audience)* |
| CHW activities |  Home visits (Total number of home visits:\_\_\_\_\_\_\_\_\_\_\_) New PWE referred to clinic (Total number: \_\_\_\_\_\_\_\_\_) Epilepsy education (Number of families educated: \_\_\_\_\_)  Others:  |
| Number of epilepsy outreach to remote areas by mobile health team | *(precise venue and estimated audience)* |
| New collaborations |  Local authorities (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Traditional healers (Number:\_\_\_\_\_\_\_\_\_\_\_) Public stakeholders (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Private stakeholders (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Others: |

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| 1. **GENERAL REMARKS FOR THE MONTH**
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| 1. **PLANS FOR THE NEXT MONTH**
 |
| Target number of health talks and venues |  |
| Target epilepsy clinic attendance |  |
| Target number of new PWE to enrol |  |
| Target number of homes to visit |  |
| Mobile epilepsy outreach to be done |  |
| New collaborations to be initiated |  |
| Other specific objectives: |  |

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name, signature and official stamp of Clinic Head:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**