VILLAGE CLINIC PNEUMONIA RECORDING FORM PatientID_________

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 (✗) if No. For PCV indicate dates of vaccine if yes							
Age	**Vaccines**						
Birth	BCG	☐	OPV-0	☐	**PCV VACCINE DATES**		
6 weeks*	DPT-Hib+ HepB 1	☐	OPV-1	☐	PCV-1	☐	Date__/___/____
10 weeks*	DPT-Hib+ HepB 2	☐	OPV-2	☐	PCV-2	☐	Date__/___/____
14 weeks*	DPT-Hib+ HepB 3	☐	OPV-3	☐	PCV-3	☐	Date__/___/____
9 months	Measles	☐					

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**

Cotrimoxazole adult tablet- 80/400

☐ Age 2 months-12 months- ½ tablet
☐ Age 12 months-5 years- 1tablet

☐ **Treat at home**

Cotrimoxazole adult tablet- 80/400

☐ Age 2 months-12 months- ½ Tablet (total 5 tablets)
☐ Age 12 months-5 years- 1tablet (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:_____/________/_______

Health Centre: Today's Date (dd/mm/yyyy):

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 ^{0}C ______________ Respiratory rate per minute ______________

Oxygen Saturation ______________ Heart Rate per minute ______________

Healthcare provider name:
(tick cadre) CO ☐ MA ☐ HSA ☐ Nurse ☐
Healthcare provider signature:
Date (dd/mm/yyyy):

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: _______
measles:	No ☐	Yes ☐	

Clinical features	Classification	Referral Decision	Treatment
CHILD 2 MONTHS TO 5 YEARS Chest in-drawing Yes ☐ No ☐ Grunting Yes ☐ No ☐ Nasal flaring Yes ☐ No ☐ Head nodding Yes ☐ No ☐ Central cyanosis Yes ☐ No ☐	Very severe pneumonia ☐	Prepare for referral ☐	Benzylpenicillin 50,000 IU/kg/dose ☐
	Severe pneumonia ☐	Prepare for referral ☐	Benzylpenicillin 50,000 IU/kg/dose ☐
Sleepy/difficult to wake Yes ☐ No ☐ Convulsions Yes ☐ No ☐ Not able to breastfeed Yes ☐ No ☐ Not able to drink Yes ☐ No ☐	Pneumonia ☐	Treat at home ☐	Cotrimoxazole 2-12 months (5 tabs) ☐ ***or*** Cotrimoxazole 12 months to 5 years (10 tabs) ☐
	PCP ☐	Prepare for referral ☐	Benzylpenicillin 50,000 IU/kg/dose ☐ ***and*** Cotrimoxazole ½ tab ☐
Stridor in calm child Yes ☐ No ☐ Wheeze Yes ☐ No ☐	Other (specify) ☐		
YOUNG INFANT < 2 MONTHS Chest in-drawing Yes ☐ No ☐ Grunting Yes ☐ No ☐ Nasal flaring Yes ☐ No ☐	Very severe pneumonia ☐	Prepare for referral ☐	Benzylpenicillin 50,000 IU/kg/dose ☐
Head nodding Yes ☐ No ☐ Central cyanosis Yes ☐ No ☐ Sleepy/difficult to wake Yes ☐ No ☐	Severe pneumonia ☐	Prepare for referral ☐	Benzylpenicillin 50,000 IU/kg/dose ☐
Not feeding well Yes ☐ No ☐ Wheeze Yes ☐ No ☐ Stridor (calm child) Yes ☐ No ☐	PCP ☐	Prepare for referral ☐	Benzylpenicillin 50,000 IU/kg/dose ☐ ***and*** Cotrimoxazole ¼ tab ☐
Apnoeic spells Yes ☐ No ☐ Convulsions Yes ☐ No ☐	Other (specify) ☐		
HIV status Positive ☐	Negative ☐	Exposed ☐ Unknown ☐	Measles at this visit or in past 2 months Yes ☐ No ☐
Blood film (malaria) Positive ☐	Negative ☐	Unknown ☐	Severe malnutrition Yes ☐ No ☐

District Hospital

District Registration No:

PNEUMONIA INPATIENT RECORDING FORM

Name:

Address: ______________________________

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 hospital: Yes ☐ No ☐ Self referral ☐ Referred by Health Centre ☐

Date of hospital admission: ____________

Weight kg ____________ MUAC cm ____________

Temperature ^{0}C ____________ Respiratory rate x 1 minute ____________

Oxygen Saturation ____________ Heart Rate per minute ____________

Chest Xray Yes ☐ No ☐

If yes date taken and results:

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: ______
MMR:	No ☐	Yes ☐	

Clinical features	Classification
CHILD 2 MONTHS TO 5 YEARS	
Chest in-drawing Yes ☐ No ☐	Very severe pneumonia ☐
Grunting Yes ☐ No ☐	
Nasal flaring Yes ☐ No ☐	Severe pneumonia ☐
Head nodding Yes ☐ No ☐	
Central cyanosis Yes ☐ No ☐	
	Pneumonia ☐
Sleepy/difficult to wake Yes ☐ No ☐	
Convulsions Yes ☐ No ☐	PCP ☐
Not able to breastfeed Yes ☐ No ☐	
Not able to drink Yes ☐ No ☐	Other (specify) ☐
Stridor in calm child Yes ☐ No ☐	
Wheeze Yes ☐ No ☐	

Treatment

Antibiotic	Dose	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Benzylpenicillin								
Amoxycillin								
Chloramphenicol								
Cotrimoxazole								
Other antibiotic (specify)								
Other treatment	Oxygen							

Clinical features	Classification
YOUNG INFANT < 2 MONTHS	
Chest in-drawing Yes ☐ No ☐	Very severe pneumonia/disease ☐
Grunting Yes ☐ No ☐	
Nasal flaring Yes ☐ No ☐	Severe pneumonia ☐
Head nodding Yes ☐ No ☐	
Central cyanosis Yes ☐ No ☐	
Sleepy/difficult to wake Yes ☐ No ☐	PCP ☐
Not feeding well Yes ☐ No ☐	Other (specify) ☐
Wheeze Yes ☐ No ☐	
Stridor (calm child) Yes ☐ No ☐	
Apnoeic spells Yes ☐ No ☐	
Convulsions Yes ☐ No ☐	

Antibiotics	Dose	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Gentamicin								
Benzylpenicillin								
Amoxycillin								
Other antibiotic (specify)								
Other treatment	Oxygen							

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 * (see below) Yes ☐ No ☐

- Severe malnutrition is visible severe wasting or oedema in both feet

please turn over

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 ☐
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