ELECTRONIC SUPPLEMENTARY MATERIAL # 1

Article title: The burden of adverse drug reactions due to Artemisinin-based anti-malarial treatment in selected Ugandan health facilities– an active follow-up study

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Questionnaire for patients

Pre-treatment form

(*To be completed on Day 0 or day of enrollment*)

Health facility name …_____

Health facility visit date…… | | | | | 2 | 0 | 1 | | **VDATE**

SECTION 1: IDENTIFICATION AND DEMOGRAPHIC DATA

1.1 Name of Patient:
NAME

1.2 Name of Village_____
VILLAGE

1.3 Section of Village (Sub-village)_____ **SECTION**

1.4 Date of Birth…… | | | | | | | | | **DOB**

1.5 Age (**in years**)…… | | | | **AGEYR**

1.6 Gender…….....

1. Male	2. Female	**SEX**

1.7 Weight (Kg) (***Put 999.9 if weight not taken***)…… | | | | . | | **WEIGHT**

1.8 Height (cm) (***Put 999.9 if height not taken***)…… | | | | . | | **HEIGHT**

1.9 Pregnant ……

1. Yes	2. No	3. Uncertain	8. NA	**PREG**

Circle NA for ALL males

1.10 Trimester …….

1. 1st	2. 2nd	3. 3rd	8. NA	**TRIME**

1.11 Patient Folder/OPD number …… | | | | | | | / | **PFOLD**

1.12 Name of Respondent:
RNAM

										PHONE1
										PHONE2

1.13 Patient/Respondent Phone Numbers ……

SECTION 2: ILLNESS AND MEDICAL INFORMATION

2.1 What are the events (signs and symptoms) at presentation within the last five day?

2.2 Did you do any malaria diagnostic test? ……..

1. Yes	2. No	**MDTT**

2.2.1 If yes, please record malaria diagnostic test

Test	**Date**								**Result (Please circle)**			
	D	**D**	**M**	**M**	**Y**	**Y**	**Y**	**Y**				
Rapid Diagnostic Test					2	0	1		1. Positive	2. Negative	3. Not Done	**MRDT**
Microscopy					2	0	1		1. Positive	2. Negative	3. Not Done	**MICR**
Other, specify ……					2	0	1					**OTST**

2.3 What generic of ACT was prescribed at this visit?

1. ASAQ	2. ALU	3. DHAPQ	4. Other……..	**GENERIC**

2.6 What type of ACT was prescribed??

1. Fixed dose	2. Loose dose	**ACTYPE**

2.6.1 Please specify brand name_____ **ACBRAND**

2.6.2 Specify the dosage, route and frequency

Dose	**Route**	**Frequency**

SECTION 3: OTHER MEDICINES:

Instructions: In this section, ask the patient about other medicines taken in last 14 days other than anti-malarials.

3.1 Did you take any other drug within in last 14 days?

1. Yes	2. No

If no, go to section 4

3.2 What is the name of the drug? (*Ask the patient if he/she has carried the medicine and ask to see it if possible, record the brand name*) _____

3.3 Did you experience any side effects after taking the drug you mentioned above?

1. Yes	2. No

3.4 Did you experience any of the following?

Symptom	New	Worsening	Symptom	New	Worsening
Vomiting			Abdominal pains		
Headache			Cough		
Body/skin rash			Itching		
Drowsiness			Nausea		
Weakness			Cold		
Dizziness			Convulsion		
Diarrhoea			Insomnia		
Other			Other		

3.5 Has the reaction stopped?

1. Yes	2. No

3.6**.** What did they do, when you reported the ADR?

1. Medicine stopped	2. Dose reduced	3. Nothing	4. Other (Specify)

3.7 **How are you feeling at the moment?**

1. Reaction recovered	2. Reaction recovering	3. Reaction continuing

SECTION 4: FOLLOW UP DETAILS

4.1 Name of nearest contact person for patient follow-up_____
NCONTACT

4.2 Nearest Contact Person Phone Number(s)…….

										NPHONE1
										NPHONE2

4.3 Date of planned follow-up visit: ……

				2	0	1		**DFOLLOW**

4.4. Name of research Assistant: ……

		FW

Patient follow-up/ Post-treatment form
(*To be completed on Day 3, 7 and 14 and **not** on day of enrollment*)

SECTION 1: IDENTIFICATION AND FOLLOW UP DETAILS

1.1 Name of Patient:_____
NAME

1.2 Date of follow-up visit | | | | | 2 | 0 | 1 | | **FODATE**

1.3 Type of follow-up visit

1. HF visit	2. Home visit	3. By phone	4. Other (specify) ……..

FOTYPE

SECTION 2 : MEDICATION AND POST CLINICAL INFORMATION

2.1 Did you take the malaria medicine you were given at the health facility?

1. Yes	No

MMED

If No, thank the participant and end Interview. If Yes, proceed to 2.2)

2.2 What is the generic name of the ACT?

1. ASAQ	2. ALU	3. DHAPQ	4. Other ……..

GENERIC

2.2.1 What type of ACT did you take?

1. Fixed dose	2. Loose dose

TYPE

2.2.2 Please, specify brand name_____
BRAND

(*If No, thank the participant and end Interview. If Yes, proceed to 2.2.4)*

2.2.3 Have you experienced any new symptoms or worsening of the old ones since you took the medication?

1. Yes	2. No

EXP_SYMP

2.2.4 Please, circle any symptoms you experienced which appear in the following table and tick (✔) whether it is **New** or **Worsening** in the corresponding box

Symptom	New	Worsening	Symptom	New	Worsening
Vomiting			Abdominal pains		
Headache			Cough		
Body/skin			Itching		

rash					
Drowsiness			Nausea		
Weakness			Cold		
Dizziness			Convulsion		
Diarrhoea			Insomnia		
Other			Other		

Please describe any other symptoms experienced apart from those mentioned above, stating whether **New** or **Worsening**

SECTION 3 : SUPERVISION AND QUALITY CHECK

3.1 Fieldworker's Code: ……			**FW**
3.2 Supervisor's Code: ……			**FS**
3.3 Form reviewed by: ……			**RB**

_____

Note: Please **NOTIFY** the Coordinator **IMMEDIATELY** if the adverse event is:

- Inability to undertake normal activities
- Life-threatening
- Resulted in persistent incapacity on disability
- Caused or prolonged hospitalization
- Resulted in congenital or birth defects
- Occurred in pregnant women
- Resulted from overdose or medication error
- Associated with a new drug