

Study # 004	CHIL DID	Plate # 401	Visit # 001	F4A_DATE
<input type="text"/>				
Site	Center	Child ID	Day	Month
				Year

Section 1: Demographic and Epidemiological Information

1. Who is [Child's Name]'s primary caretaker? **PRIMCARE**

<input type="checkbox"/> 1 Mother	<input type="checkbox"/> 2 Father	<input type="checkbox"/> 3 Sister	<input type="checkbox"/> 4 Brother
<input type="checkbox"/> 5 Grandmother	<input type="checkbox"/> 6 Grandfather	<input type="checkbox"/> 7 Aunt	<input type="checkbox"/> 8 Uncle
<input type="checkbox"/> 9 No relation	<input type="checkbox"/> 10 Other relation by blood or marriage, specify <u>PRIMCARE_SPEC</u>		

2. What is your relationship to [Child's Name]? **RELATIONSHIP**

<input type="checkbox"/> 1 Mother	<input type="checkbox"/> 2 Father	<input type="checkbox"/> 3 Sister	<input type="checkbox"/> 4 Brother
<input type="checkbox"/> 5 Grandmother	<input type="checkbox"/> 6 Grandfather	<input type="checkbox"/> 7 Aunt	<input type="checkbox"/> 8 Uncle
<input type="checkbox"/> 9 No relation	<input type="checkbox"/> 10 Other relation by blood or marriage, specify <u>RELATION_SPEC</u>		

3. Where does [Child's Name]'s mother live? **MOM_LIVE**

<input type="checkbox"/> 1 Living in household	<input type="checkbox"/> 3 Abroad	<input type="checkbox"/> 5 Died
<input type="checkbox"/> 2 Lives outside of household	<input type="checkbox"/> 4 Whereabouts unknown	

4. Where does [Child's Name]'s father live? **DAD_LIVE**

<input type="checkbox"/> 1 Living in household	<input type="checkbox"/> 3 Abroad	<input type="checkbox"/> 5 Died
<input type="checkbox"/> 2 Lives outside of household	<input type="checkbox"/> 4 Whereabouts unknown	

5. How far did the child's primary caretaker go in school? **PRIM_SCHL**

<input type="checkbox"/> 1 No formal schooling	<input type="checkbox"/> 4 Completed secondary
<input type="checkbox"/> 2 Less than primary	<input type="checkbox"/> 5 Post-secondary
<input type="checkbox"/> 3 Completed primary	<input type="checkbox"/> 6 Religious education only
	<input type="checkbox"/> 7 Don't know

6. How many people have been living regularly in your household for the past 6 months? **PPL_HOUSE**

7. How many people have been sleeping regularly in your household for the past 6 months? **PPL_SLEEP**

8. How many children younger than 60 months live in the household? **YNG_CHILDREN**



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9. How many rooms in your household are used for sleeping?

SLP_ROOMS

10. What is the predominant floor in the house of [Child's Name]?

FLOOR

Natural FloorRudimentary FloorFinished Floor 1 Earth/Sand 3 Wood planks 5 Parquet or polished wood 2 Dung 4 Palm/bamboo 6 Vinyl or asphalt strips 7 Ceramic Tile 8 Cement 9 Carpet 10 Other, specify _____

11. Does your household have the following? [Must be functioning; "X" all that apply.]

HOUSE_PHONE

 1 Electricity 1 Bicycle/rickshaw 1 Telephone (mobile or non-mobile) 1 Television 1 Car/truck 1 Animal-drawn cart 1 Motorcycle/scooter 1 Refrigerator 1 Agricultural land 1 HOUSE_RADIO 1 HOUSE_BOAT

HOUSE_AGLAND

 1 Radio 1 Boat with a motor 1 None of the above

HOUSE_NONE

12. What type of cooking fuel does your household use? [“X” all that apply.]

FUEL_GRASS

 1 Electricity 1 Biogas 1 Straw/shrubs/grass 1 FUEL_PROPANE 1 FUEL_COAL

FUEL_DUNG

 1 Liquid Propane Gas 1 Coal/lignite 1 Animal dung 1 FUEL_NATGAS 1 FUEL_CHARCOAL

FUEL_CROP

 1 Natural Gas 1 Charcoal 1 Agricultural crop residue 1 FUEL_KERO 1 Wood

FUEL_OTHER

 1 Kerosene 1 FUEL_WOOD 1 Other, specify _____

13. Do the following animals live in the compound where [Child's Name] lives? [“X” all that apply.]

 1 Goat ANI_GOAT 1 Cow ANI_COW 1 No Animals ANI_NO 1 Sheep ANI_SHEEP 1 Rodents ANI_RODENTS 1 Dog ANI_DOG 1 Fowl (chicken, duck or other birds) 1 Cat ANI_CAT 1 Other, specify ANI_SPEC



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14. During the last two weeks, has your household ever obtained drinking water from any of the following sources? [“X” all that apply.]

<input type="checkbox"/> Piped into house	WATER_HOUSE	<input type="checkbox"/> Covered well in house or yard	WATER_COVWELL
<input type="checkbox"/> Piped into yard	WATER_YARD	<input type="checkbox"/> Covered public well	WATER_COVPWELL
<input type="checkbox"/> Public tap	WATER_PUBTAP	<input type="checkbox"/> Protected spring	WATER_PROSPRING
<input type="checkbox"/> Open well in house or yard	WATER_WELL	<input type="checkbox"/> Unprotected spring	WATER_UNSPRING
<input type="checkbox"/> Open public well	WATER_PUBWELL	<input type="checkbox"/> River or stream	WATER_RIVER
<input type="checkbox"/> Pond or lake	WATER_POND	<input type="checkbox"/> Dam or earth pan	WATER_DAM
<input type="checkbox"/> Deep tube well	WATER_DEEPWELL	<input type="checkbox"/> Rainwater	WATER_RAIN
<input type="checkbox"/> Shallow tube well	WATER_SHALLWELL	<input type="checkbox"/> Bought (tank, bottles, etc)	WATER_BOUGHT
<input type="checkbox"/> Other, specify	WATER_OTHR WATER_SPEC	<input type="checkbox"/> Bore hole	WATER_BORE

15. During the last two weeks, what was the **main source** of drinking water for the members of your household? [“X” only one response that relates to the main source of drinking water.]

[MS_WATER](#)

<input type="checkbox"/> Piped into house	<input type="checkbox"/> Covered well in house or yard
<input type="checkbox"/> Piped into yard	<input type="checkbox"/> Covered public well
<input type="checkbox"/> Public tap	<input type="checkbox"/> Protected spring
<input type="checkbox"/> Open well in house or yard	<input type="checkbox"/> Unprotected spring
<input type="checkbox"/> Open public well	<input type="checkbox"/> River or stream
<input type="checkbox"/> Pond or lake	<input type="checkbox"/> Dam or earth pan
<input type="checkbox"/> Deep tube well	<input type="checkbox"/> Rainwater
<input type="checkbox"/> Shallow tube well	<input type="checkbox"/> Bought (tank, bottles, etc)
<input type="checkbox"/> Other, specify	MS_SPEC
	<input type="checkbox"/> Bore hole

[Use your response from Question 15 to answer Questions 16 and 17. If the response to Question 15 is “piped into house/yard”, “open or covered well in house/yard” or “rainwater”, then go to Question 18. Otherwise continue.]



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16. How long does it take to go there, get water, and come back?

TIME_WATER

1 Less than 15 minutes

4 1 to 3 hours

2 15 to 29 minutes

5 More than 3 hours

3 30 to 59 minutes

17. Do you or other members from your household go and fetch drinking water for the household every day?

No

Yes

FETCH_WATER 0 1

[If "Yes", go to Question 17a, if "No" go to Question 17b.]

17a. On average, how many trips do you and members from your household make to fetch water each day?

Number of trips/day

TRIP_DAY

17b. On average, how many trips do you and members from your household make to fetch water each week?

[If no trips are made, complete as "00".]

Number of trips/week

TRIP_WEEK

18. In the last two weeks, how often has water been available from this main source?

1 All the time

3 A few times per week

WATER_AVAIL

2 Several hours every day

4 Less frequent than a few times per week

19. In the last two weeks, did you give [Child's Name] stored water for drinking?

STORE_WATER

No

Yes

 0 1

20. Do you usually treat drinking water at home?

TRT_WATER

No

Yes

 0 1

21. Which method do you use the most to treat drinking water at home? [“X” only one response.]

TRT_METHOD

1 Leave water in sun to disinfect

4 Boil

2 Filter through a cloth

5 Filter through ceramic or other filter

3 Chlorine liquid, powder, or tablets

6 Alum

7 Other chemical or additive, specify _____

TRT_METHOD_SPEC

[If chlorine is not used, skip to Question 22.]

21a. If you use chlorine liquid, powder or tablets, which type do you most commonly use? [“X” only one response.]

CHLORINE

1 Certeza

5 Watermaker

2 Aquatabs

6 PuR

3 AquaGuard

7 Unknown

4 WaterGuard

8 Other, specify _____

CHLORINE_SPEC



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NOTRT_WATER

No

Yes

22. In the last two weeks did you give [Child's Name] water which was not treated?

23. How do you usually dispose of [Child's Name]'s feces? [“X” only one response.]

Scatter in yard DISP_FECES

Bush/Field/Ground/Stream/Open sewer

Bury

Do nothing

Toilet, latrine

Other, specify _____

DISP_SPEC

24. What kind of facility does your household most commonly use to dispose of human fecal waste?

[Show pictures to confirm the identity of the facility used. “X” only one response.]

Flush toilet FAC_WASTE

Pour flush toilet

Ventilated improved pit (VIP) latrine

No facility: Bush/Field/Ground/Stream/Open sewer

Traditional pit toilet

If “No facility” selected, go to Question 26

Ventilated improved pit w/water seal

Other, specify _____

FAC_SPEC

25. How many households (other than your own) share this facility?

[Respond with a number; code “00” for none.]

SHARE_FAC

26. When do you usually wash your hands? [“X” all that apply. Do not probe.]

Before eating WASH_EAT

WASH_ANIMAL After handling domestic animals

Before cooking WASH_COOK

WASH_CHILD After cleaning child who defecated

Before you nurse or prepare baby's food WASH_NURSE

WASH_NEVER Never

After you defecate WASH_DEF

WASH_OTHR Other, specify _____

WASH_SPEC

27. When you wash your hands, what do you usually use? [“X” only one.] WASH_USE

Water only

Water and soap

Water and ashes

Water and mud or clay

Section 2: Clinical Information

28. Is [Child's Name] currently breastfed? BREASTFED

No

Partial breastfeeding

Exclusive breastfeeding

29. How many days including today has this episode of diarrhea lasted? DRH_DAYS



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30. Since *[Child's Name]* became ill with diarrhea, how would you best describe the stool?

["X" the most common.]

DRH_STOOLS

1 Simple watery 2 Rice watery stool 3 Sticky/mucoid 4 Bloody

31. During the illness, what was the maximum number of loose stools that *[Child's Name]* passed in a day (24-hour period)? ["X" only one response.]

MAX_STOOLS

1 ≤ 6 per day 2 7 to 10 times per day 3 More than 10 times per day

32. Did *[Child's Name]* have any of the following since this illness began?

		No	Yes	DK
a.	Blood in stools	DRH_BLOOD	0	1
b.	Vomiting 3 or more times per day	DRH_VOMIT	0	1
c.	Very thirsty	DRH_THIRST	0	1
d.	Drank much less than usual	DRH_LESSDRINK	0	1
e.	Unable to drink	DRH_UNDRINK	0	1
f.	Belly pain	DRH_BELLYPAIN	0	1
g.	Fever measured <u>at least</u> 38°C or parental perception	DRH_FEVER	0	1
h.	Irritable or restless	DRH_RESTLESS	0	1
i.	Decreased activity or lethargy	DRH_LETHRGY	0	1
j.	Loss of consciousness	DRH_CONSC	0	1
k.	Rectal straining	DRH_STRAIN	0	1
l.	Rectal prolapse	DRH_PROLAPSE	0	1
m.	Cough	DRH_COUGH	0	1
n.	Difficulty breathing	DRH_BREATH	0	1
o.	Convulsion	DRH_CONV	0	1



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33. Right now, does your child have any of the following?

		No	Yes	DK
a.	Very thirsty	CUR_THIRSTY	0	1
b.	Drinks poorly or not able to drink	CUR_NODRINK	0	1
c.	Sunken eyes	CUR_SUNKEYES	0	1
d.	Wrinkled skin	CUR_SKIN	0	1
e.	Irritable or restless	CUR_RESTLESS	0	1
f.	Lethargy or loss of consciousness	CUR_LETHRGY	0	1
g.	Dry mouth	CUR_DRYMOUTH	0	1
h.	Fast breathing	CUR_FASTBREATH	0	1

34. Before coming to this hospital/health center, was [Child's Name] given any of the following to treat his/her diarrhea? [“X” all that apply. Start with open-ended question; then probe options if not mentioned by the caretaker.]

HOMETRT_ORS

A fluid made from a special packet called ORALITE or ORS?

HOMETRT_MAIZE

Homemade fluid (e.g., Thin watery porridge made from maize, rice or wheat, soup, sugar salt water solution, Yogurt based drink)

HOMETRT_MILK

Special milk or infant formula

HOMETRT_OTHR1Q

HOMETRTLIQ_SPEC

HOMETRT_HERB

Home remedy/Herbal medication

HOMETRT_AB

HOMETRT_AB_SPEC

HOMETRT_ZINC

Zinc (tablet/syrup)

HOMETRT_OTHR1

HOMETRT_SPEC1

HOMETRT_NONE

No special remedies given

HOMETRT_OTHR2

HOMETRT_SPEC2

35. Since [Child's Name] developed diarrhea, how much have you been offering [Child's Name] to drink?

OFFR_DRINK

More than usual Much less than usual

Usual Nothing to drink

Somewhat less than usual

36. Since [Child's Name] developed diarrhea, how much have you been offering [Child's Name] to eat?

OFFR_EAT

More than usual Much less than usual

Usual Nothing to eat

Somewhat less than usual

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<input type="checkbox"/> Site	<input type="checkbox"/> <input type="checkbox"/> Center	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child ID

Section 3: Health care utilization and expenses made before this visit to this hospital/health center

37. Before coming to this hospital/health center, did you seek care for [Child's Name] outside your household for this illness?

[If "No", go to Question 41.]

SEEK_OUTSIDE 0 No 1 Yes

38. If you previously sought care for [Child's Name] for this illness, where did you go? [Use the Health Facility Coding List to code the center(s) of choice. Do not include this center. "X" all that apply.]

SEEK_PHARM 1 Pharmacy

SEEK_FRIEND 1 Friend/relative

SEEK_HEALER 1 Traditional healer

SEEK_DOC 1 Unlicensed practitioner/village doctor/bush doctor/village health worker

SEEK_PRIVDOC 1 Licensed practitioner/private doctor (not at hospital)

SEEK_REMDY 1 Bought a remedy/medicine at the shop/market, specify remedy/drug SEEK_REMDY_SPEC

SEEK_CTR1 1 Hospital/Center of first choice **SEEK_CTR1_CODE** **SEEK_CTR1_SHC** 1=SHC, 0_NonSHC

SEEK_CTR2 1 Hospital/Center of second choice **SEEK_CTR2_CODE** **SEEK_CTR2_SHC** 1=SHC, 0_NonSHC

SEEK_CTR3 1 Hospital/Center of third choice **SEEK_CTR3_CODE** **SEEK_CTR3_SHC** 1=SHC, 0_NonSHC

SEEK_OTHER 1 Other Hospital/Center, specify SEEK_OTHER_SPEC

39. What were your or your household estimated out-of-pocket expenses for the following: [Have respondent answer for only those facilities (not friends or relatives) that were used in Question 38 and provide the expense in the local currency.]

Total Medical Expenses

Transportation

a. Pharmacy **PHARM_TOTAL**

PHARM_TRNSPRT

<input type="checkbox"/>					
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<input type="checkbox"/>					
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b. Traditional healer **HEAL_TOTAL**

HEAL_TRNSPRT

<input type="checkbox"/>					
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<input type="checkbox"/>					
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c. Unlicensed practitioner/village doctor/bush doctor **DOC_TOTAL** **DOC_TRNSPRT**

<input type="checkbox"/>					
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<input type="checkbox"/>					
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

d. Licensed practitioner/private doctor **PRIVDOC_TOTAL** **PRIVDOC_TRNSPRT**

<input type="checkbox"/>					
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<input type="checkbox"/>					
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e. Bought remedy/medicine at the shop/market **REMDY_TOTAL** **REMDY_TRNSPRT**

<input type="checkbox"/>					
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<input type="checkbox"/>					
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Total Medical Expenses

Transportation

f. Hospital/Center of 1st choice **CTR1_TOTAL**

CTR1_TRNSPRT

<input type="checkbox"/>					
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g. Hospital/Center of 2nd choice **CTR2_TOTAL** **CTR2_TRNSPRT**

<input type="checkbox"/>					
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h. Hospital/Center of 3rd choice **CTR3_TOTAL** **CTR3_TRNSPRT**

<input type="checkbox"/>					
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i. Other, specify **OTHER_SPEC** **OTHER_TOTAL** **OTHER_TRNSPRT**

<input type="checkbox"/>					
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40. Where did the money come from? [“X” all that apply. Start with open-ended question; then probe options if not mentioned by the caretaker.]

<input type="checkbox"/> 1	Cutting down expenses from meal	MONEY_MEAL
<input type="checkbox"/> 1	Cutting down from other expenses	MONEY_OTHEXP
<input type="checkbox"/> 1	Using savings	MONEY_SVNGS
<input type="checkbox"/> 1	Borrowing	MONEY_BORROW
<input type="checkbox"/> 1	Selling assets	MONEY_ASSET
<input type="checkbox"/> 1	Asking for donations outside the household	MONEY_DONAT
<input type="checkbox"/> 1	Relative or friend pays on your behalf	MONEY_RELATIVE
<input type="checkbox"/> 1	Others, specify _____	MONEY_SPEC
		MONEY_OTHR

Section 4: Health Care Expenses when leaving the hospital/health center

☞ [Complete this section when the child leaves the health center after an outpatient visit or at discharge after admission.]

41. How long did it take to get here from your home (including the journey time and any time waiting for transport)?

TRNSPORT_TIME

<input type="checkbox"/> 1	Less than 15 minutes	<input type="checkbox"/> 4	1 to 4 hours
<input type="checkbox"/> 2	15 minutes to 29 minutes	<input type="checkbox"/> 5	More than 4 hours
<input type="checkbox"/> 3	30 to 59 minutes	<input type="checkbox"/> 6	Don't know

42. If you paid for transportation to bring the child to the hospital or clinic, how much did you pay?

TRNS_INIT_PAY

Local currency

43. Other than the first trip to bring the child to the health center, how much did you pay for transport to or from this facility during the child's stay in the facility?

TRNS_YOU_PAY

Local currency

44. How much have other members of your household paid for transport to or from this facility as a result of the child's stay in the facility?

TRNS_OTHER_PAY

Local currency



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45. What are your estimated out-of-pocket expenses for the following [This information applies to the period of hospitalization or visit to this center. Use the local currency.]:

Consultation:

EXPEN_CONSULT

Drugs:

EXPEN_DRUG

Diagnostics:

EXPEN_DIAG

Food:

EXPEN FOOD

Other, specify: _____

EXPEN_SPEC

EXPEN_OTHR

[Only if the respondent cannot break down the expenses, use the "Total" row.

DO NOT CALCULATE THE "TOTAL" FROM ALL THE ROWS.

Total:

EXPEN_TOTAL

46. Where did the money that you spent during this visit or hospitalization come from? ["X" all that apply. Start with open-ended question; then probe options if not mentioned by the caretaker.]

SPENT_MEAL Cutting down expenses from mealsSPENT_ASSET Selling assetsSPENT_OTHEXP Cutting down from other expensesSPENT_DONAT Asking for donations outside the householdSPENT_SVNGS Using savingsSPENT_RELATIVE Relative or friend pays on your behalfSPENT_BORROW BorrowingSPENT_OTHR Other, specify: _____ SPENT_SPEC

[Answer Questions 47 to 50 for the time period starting from the beginning of the illness until today.]

47. Did you lose some earnings due to seeking or providing care during [Child's Name] illness?

LOSE_EARN No Yes

LOSE_TOTAL

If yes, how much? _____

[Use local currency.]

48. Did other caregivers lose some earnings due to seeking or providing care during [Child's Name] illness?

OTHROLOSE_TOTAL

OTHROLOSE_EARN No Yes DK

If yes, how much? _____

[Use local currency.]

49. How much time have you spent taking care of [Child's name] when otherwise you would have been doing income generating activities (farming, selling in the market, working in a private business, etc.)?

[Half a morning or afternoon = 0.25 days, a morning or afternoon = 0.50 days, a morning and afternoon = 1.00 day, anything less than half a morning or afternoon = 0 days.]

DAYSLOST_CARE

.

Day(s)



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50. How much time have other caregivers spent taking care of *[Child's name]* when otherwise they would have been doing income generating activities (farming, selling in the market, working in a private business, etc.)? *[Half a morning or afternoon = 0.25 days, a morning or afternoon = 0.50 days, a morning and afternoon = 1.00 day, anything less than half a morning or afternoon = 0 days.]*

DAYSLOST_OTHRCRE . Day(s)

END OF THE INTERVIEW.
THANK THE RESPONDENT(S) FOR THEIR COOPERATION.

Place sticker of Specimen ID here.

SPECIMEN_ID

51. Specimen ID:

Notes or comments *[Initial and date notes]*

Interviewer's Name _____

INT_CODE

Staff code

Quality Control's Name _____

QC_CODE

Staff code

QC_DATE

Day

Month

Year

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<input type="text"/>				
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				Year

Section 1: Physical Findings

1. Physical findings:

a. Weight WEIGHT

0-23 months old: (Weight of caretaker with and without child): WT_CHILD . kg Caretaker + child WT_CARE . kg Caretaker alone

24-59 months old: (Weight of child alone) WT . kg

b. Height HEIGHT HT1 1st . cm HT2 . cm HT3 . cm

c. MUAC MUAC MUAC1 1st . cm MUAC2 . cm MUAC3 . cm

d. Axillary temperature TEMP . °C

e. Respiratory rate per minute RESP RESP1 1st . RESP2 2nd .

f. Chest indrawing CHEST_INDRW No Yes

EYES g. Eyes 0 Normal 1 Sunken *[Confirm with the mother that the eyes are more sunken than usual.]*

MOUTH h. Mouth 0 Normal 1 Somewhat dry 2 Very dry

SKIN i. Skin pinch 0 Normal 1 Slow return *[≤ 2 sec.]* 2 Very slow *[> 2 sec.]*

MENTAL j. Mental status 0 Normal 1 Restless, irritable 2 Lethargic/unconscious

Absent *Present*

k. Rectal prolapse 0 1 RECTAL

l. Bipedal edema *[Both feet]* 0 1 BIPEDAL

m. Abnormal hair: sparse, loose, straight 0 1 ABN_HAIR

n. Undernutrition: wasted/very thin 0 1 UNDER_NUTR

o. Skin has 'flaky paint' appearance 0 1 SKIN_FLAKY

2. Did either the interviewer or the study staff observe a stool sample from this child? No Yes

[If "Yes", go to Question 3, if "No" go to Question 4.] OBSERVE_STOOL 0 1

3. If yes, what was the nature of the stool? *[X only one.]* NATURE_STOOL

1 Loose/liquid stool without blood 2 Loose/liquid stool with blood 0 Normal stool



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4. Does the child require rehydration? CHILD_REHYD

No Yes, Oral rehydration Yes, IV rehydration

[If 'No', go to Section 3]

5. Will [Child's Name] receive recommended rehydration at this hospital/health center?

Yes No, referred to another center No, parents refused Prescribed ORS for
RECOMMEND administration at home

Section 2: Outcome after rehydration

[Complete this Section if the child received rehydration therapy (oral or intravenous) in the health facility.]

Outcome 4 hours after starting rehydration

[Obtain the following information 4 hours after starting rehydration therapy (oral or intravenous). If the child leaves the facility before 4 hours have passed, skip this Section and proceed to Section 3.]

No Yes
6. Was the child evaluated after 4 hours? CHILD_EVAL

a. If "No", what was the reason? CHILD_EVAL_SPEC

[If you were not able to do the evaluation after 4 hours, complete the reason and proceed to Section 3 below.]

7. Findings after 4 hours of rehydration:

a. Weight FIND_WEIGHT

0-23 months old: (Weight of caretaker with and without child): . kg . kg
Caretaker + child . kg *Caretaker alone*

24-59 months old: (Weight of child alone): . kg

FIND_MOUTH

b. Mouth Normal Somewhat dry Very dry

c. Skin pinch Normal Slow return [≤ 2 sec.] Very slow [>2 sec.]

No Yes
8. Does the child continue to purge large volumes of watery stool? CHILD_PURGE

9. Was the total stool output within the last four hours measured? CHILD_OUTPUT

a. If "Yes", what was the volume? ml VOLUME

CHILD_IV

10. Does the child require additional oral/IV fluid for rehydration? No [skip to section 3] Yes

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15. A child may receive medication in the hospital and/or receive a prescription for treatment at home. For each of the following medications, cross [“X”] the appropriate boxes. [“X” all that apply.]

Given
prescription
for treatment
at homeTreatment
given in health
centerGiven
prescription
for treatment
at homeTreatment
given in health
center

TRT_PRES_ORS TRT_GIVE_ORS

TRT_PRES_AMPI

TRT_GIVE_AMPI

TRT_PRES_IV TRT_GIVE_IV

TRT_PRES_NALID

TRT_GIVE_NALID

TRT_PRES_CXL TRT_GIVE_CXL

TRT_PRES_CPNR

TRT_GIVE_CPNR

TRT_PRES_FOOD TRT_GIVE_FOOD

TRT_PRES_SLPY

TRT_GIVE_SLPY

TRT_PRES_GENT TRT_GIVE_GENT

TRT_PRES_OTHR

TRT_GIVE_OTHR TRT_SPEC

TRT_PRES_CHLOR TRT_GIVE_CHLOR

TRT_PRES_ZINC

TRT_GIVE_ZINC

TRT_PRES_ERY TRT_GIVE_ERY

TRT_PRES_HOME

TRT_GIVE_HOME

TRT_PRES_AZI TRT_GIVE_AZI

TRT_PRES_ANTI

TRT_GIVE_ANTI

TRT_PRES_MACR TRT_GIVE_MACR

TRT_PRES_OTHR1

TRT_GIVE_OTHR1 TRT_SPEC1

TRT_PRES_PEN TRT_GIVE_PEN

TRT_PRES_OTHR2

TRT_GIVE_OTHR2 TRT_SPEC2

TRT_PRES_AMOX TRT_GIVE_AMOX

TRT_PRES_OTHR3

TRT_GIVE_OTHR3 TRT_SPEC3

1 Amoxicillin

TRT_NONE None prescribed/taken

16. Outcome when leaving hospital/health center. [“X” only one response.]

 1 Resolved or healthy

OUTCOME

 2 Improved 3 No better 4 Worse 5 Died in hospital/health center 6 Unknown/lost to follow up

[If the child died, complete Question 16a and make sure a verbal autopsy will be completed according to local guidelines. Medical information will be collected using CRF10.]

DATE_DEATH

16a. If the child died, what was the date of death:

Day

Month

Year

Notes or comments [Initial and date notes]

Interviewer's Name _____	INT_CODE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	----------	--------------------------	--------------------------	--------------------------

Staff code

Quality Control's Name _____	QC_CODE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
------------------------------	---------	--------------------------	--------------------------	--------------------------

QC_DATE

Staff code

VRG Updated 22Aug2011

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Day

Month

Year



Study # 004

CHILDID

Plate # 051

Visit # 002

F5_DATE

Site

Center

Child ID

Day

Month

Year

CASE_CONTROL

Choose one: Case-child Control-child

Variable names are prefaced with F5_

Interview Outcome

1. What was the outcome of the follow-up interview?

 Conducted STATUS Not conducted

NOT_CONDUCT

If "Not conducted", what was the reason?

 Child cannot be found Caretaker refused Caretaker not available after 3 visits Other, specify _____ NOT_CONDUCT_SPEC

[If the interview was not conducted, complete the above part, sign, date, and submit this page to the DCC.]

Notes or comments [Initial and date notes]

INT_CODE

Interviewer's Name _____

Staff code

QC_DATE

Quality Control's Name _____

QC_CODE

Staff code

Day

Month

Year



Study # 004

Plate # 052

Visit # 002

Site

Center

Child ID

Section 1: Clinical Information

2. What is your relationship to [Child's Name]?

RELATION

<input type="checkbox"/> 1 Mother	<input type="checkbox"/> 2 Father	<input type="checkbox"/> 3 Sister	<input type="checkbox"/> 4 Brother
<input type="checkbox"/> 5 Grandmother	<input type="checkbox"/> 6 Grandfather	<input type="checkbox"/> 7 Aunt	<input type="checkbox"/> 8 Uncle
<input type="checkbox"/> 9 No relation	<input type="checkbox"/> 10 Other relation by blood or marriage, specify _____	RELATION_SPEC	

3. How is [Child's Name]'s health since the last study visit? [Explain to caretaker what is meant by "the last study visit".]

CHILD_HEALTH

<input type="checkbox"/> 1 Appears healthy	<input type="checkbox"/> 4 Health has deteriorated
<input type="checkbox"/> 2 Health improved but not back to normal	<input type="checkbox"/> 5 Died
<input type="checkbox"/> 3 No better/unchanged	

[If died, complete "a" to "c" below.]

DATE_DEATH

a. If [Child's Name] died, what was the date of death?

Day

Month

Year

b. If [Child's Name] died, what was the place of death?

<input type="checkbox"/> 1 Health facility	<input type="checkbox"/> 2 Home or elsewhere	PLACE_DEATH
--	--	-------------

c. If the child died in a health facility, what was the name of the health facility?

[Use the Health Facility Coding List to code the facility; if the health facility is not coded, use '090' and insert the name below; if health facility unknown, use '999'.]

DIED_FACILITY

FACILITY_SPEC

If the child died, make sure a verbal autopsy will be completed (and medical information will be collected if the child died in a health facility) according to the local guidelines. For children who died, the remainder of the questionnaire needs to be completed except Section 2.]



Study # 004

Plate # 054

Visit # 002

Site

Center

Child ID

Absent Present

f. Rectal prolapse	<input type="checkbox"/> 0	<input type="checkbox"/> 1	RECTAL
g. Bipedal edema [<i>Both feet</i>]	<input type="checkbox"/> 0	<input type="checkbox"/> 1	BIPEDAL
h. Abnormal hair: sparse, loose, straight	<input type="checkbox"/> 0	<input type="checkbox"/> 1	ABN_HAIR
i. Undernutrition: wasted/very thin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	UNDER_NUTR
j. Skin has 'flaky paint' appearance	<input type="checkbox"/> 0	<input type="checkbox"/> 1	SKIN_FLAKY

Section 3: Water-Sanitation-Environment

8. During the last two weeks, what was the **main source** of drinking water for the members of your household? [*"X"* only one response that relates to the main source of drinking water.]

<input type="checkbox"/> 1 Piped into house	MS_WATER	<input type="checkbox"/> 9 Covered well in house or yard
<input type="checkbox"/> 2 Piped into yard		<input type="checkbox"/> 10 Covered public well
<input type="checkbox"/> 3 Public tap		<input type="checkbox"/> 11 Protected spring
<input type="checkbox"/> 4 Open well in house or yard		<input type="checkbox"/> 12 Unprotected spring
<input type="checkbox"/> 5 Open public well		<input type="checkbox"/> 13 River or stream
<input type="checkbox"/> 6 Pond or lake		<input type="checkbox"/> 14 Dam or earth pan
<input type="checkbox"/> 7 Deep tube well		<input type="checkbox"/> 15 Rainwater
<input type="checkbox"/> 8 Shallow tube well		<input type="checkbox"/> 16 Bought (tank, bottles, etc)
<input type="checkbox"/> 18 Other, specify _____	MAIN_SPEC	<input type="checkbox"/> 17 Bore hole

[Interviewer should ask to see the containers where drinking water is usually stored; based on your observations, complete parts "a" to "d" below.]

8a. Observed container(s) in use in the home? No Yes 0 1 MAIN_CONT

If "No", go to Question 9.]

8b. Type of container observed. [*"X"* only one response] MAIN_TYPE

- 1 Wide-mouthed container(s) - 6 cm or more across the opening
- 2 Narrow-mouthed container(s) - less than 6 cm across the opening
- 3 Mixture of wide and narrow-mouthed containers
- 4 Other, specify: _____ MAIN_TYPE_SPEC

No Yes Mixed (covered and uncovered)

8c. Are containers covered? 0 1 2 MAIN_CONTAINCOV



Study # 004

Plate # 055

Visit # 002

Site

Center

Child ID

8d. How is water removed from container? [*"X" all that apply.*]**WATER_POUR** Pour (spigot or spout)**WATER_CUP** Scoop with cup**WATER_LADLE** Scoop with ladle

No

Yes

9. Do you usually treat your drinking water at home?

 TREAT_WATER

[If "No", go to Question 11.]

10. Which method do you use the most to treat drinking water at home? [*"X" only one response.*]**TRT_METH**

Method reported

Materials observed for method reported

 Leave water in sun**TRTOBS_SUN**

No

Yes

 Boiled

By observation

TRTOBS_BOIL Filter through a cloth

Cloth observed

TRTOBS_FILTER Ceramic/other filter

Filter observed

TRTOBS_CRM Chlorine

Tablet/liquid/powder observed

TRTOBS_CHLR Alum

Alum observed

TRTOBS_ALUM Other chemical

Chemical observed

TRTOBS_CHEMSpecify TRT_SPEC Other method

Method observed

TRTOBS_OTHR Specify TRT_SPEC2

[If chlorine is not used, go to Question 11]

10a. If chlorine is the method of water treatment in Q10, record the chlorine test result.

 Positive (yellow) Refused test **CHLR_WATER** Negative (clear) No water in the container

10b. If chlorine is the method of water treatment in Q10, check the brands that you observed.

[*"X" all that apply.*]**BRD_CERTEZA** Certeza**BRD_WTRGUARD****BRD_UNKNOWN****BRD_AQUATAB** Aquatabs WaterGuard**BRD_WTRMAKE** Unknown**BRD_AQUAGU** AquaGuard Watermaker**BRD_PUR** **BRD_NA** Not applicable (none observed)**BRD_OTHER** PuR Other, specify BRD_OTHER_SPEC

11. Where do you usually wash your hands?

WASH_WHERE In or near dwelling/yard Another place

[If "Another place", go to Question 13.]



Study # 004

Plate # 056

Visit # 002

Site

Center

Child ID

12. If hands are washed in or near dwelling/yard, ask to see the place and record whether the following items are present:

No	Yes	No	Yes
<input type="checkbox"/> 0	<input type="checkbox"/> 1 WASH_PIPE	<input type="checkbox"/> 0	<input type="checkbox"/> 1 Basin WASH_BASIN
<input type="checkbox"/> 0	<input type="checkbox"/> 1 Piped water source WASH_NOPTAP	<input type="checkbox"/> 0	<input type="checkbox"/> 1 Soap WASH_SOAP
<input type="checkbox"/> 0	<input type="checkbox"/> 1 Non-piped water source without tap WASH_TAP	<input type="checkbox"/> 0	<input type="checkbox"/> 1 Ash, mud or clay WASH_ASH
<input type="checkbox"/> 0	<input type="checkbox"/> 1 Non-piped water source with tap		

13. Please show me where you usually dispose of the feces of your child. [*“X” one only.*]

<input type="checkbox"/> 1 Flush toilet	CHILD_FECES	<input type="checkbox"/> 4 Pour flush latrine
<input type="checkbox"/> 2 Ventilated improved pit (VIP) latrine		<input type="checkbox"/> 5 Bush/Field/Ground/Stream/Open sewer*
<input type="checkbox"/> 3 Traditional pit toilet		<input type="checkbox"/> 6 Other, specify <u>CHILD_FECES_SPEC</u>

[*The option “Bush/Field/Ground/Stream/Open sewer” includes dumping anywhere in the environment outside the compound.]

14. [Interviewer, record whether feces observed]:

	No	Yes
14a. Visible feces observed in defecation area	<input type="checkbox"/> 0	<input type="checkbox"/> 1 FECES_VISIBLE
14b. Visible feces observed elsewhere in house or yard	<input type="checkbox"/> 0	<input type="checkbox"/> 1 FECES_ELSE

15. Please show me the facility your household most commonly use to dispose of human fecal waste. [*“X” one only.*]

<input type="checkbox"/> 1 Flush toilet	HOUSE_FECES	<input type="checkbox"/> 4 Pour flush toilet
<input type="checkbox"/> 2 Ventilated improved pit (VIP) latrine		<input type="checkbox"/> 5 No facility: Bush/Field/Ground/Stream/Open sewer
<input type="checkbox"/> 3 Traditional pit toilet		<input type="checkbox"/> 6 Other, specify <u>HOUSE_FECES_SPEC</u>
<input type="checkbox"/> 7 Ventilated improved pit w/water seal		

END OF INTERVIEW. THANK RESPONDENT(S) FOR THEIR COOPERATION.

Notes or comments [Initial and date notes]

Interviewer's Name _____ **INT_CODE2**

Staff code

QC_DATE2

Quality Control's Name _____ **QC_CODE2**

Staff code

Day

Month

Year

Study # 004	CHIL DID	Plate # 061	Visit # 001	F6_DATE
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Site	Center	Child ID (Control)	Day	Month
				Year

Index Case's Information

		CASE_DOB		CASE_AGE	Version #
1. Birthdate of index case:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Age: <input type="checkbox"/> <input type="checkbox"/>	2 Version
	Day	Month	Year		
2. Gender of index case:	<input type="checkbox"/> 0 Boy	<input type="checkbox"/> 1 Girl	CASE_GENDER		
3. Date of enrollment of index case:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CASE_ENROLL	
	Day	Month	Year		
4. Child ID Number of index case:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			CASE_ID	

Control's Information

		BIRTH_DATE		AGE
5. Child's birthdate:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Age: <input type="checkbox"/> <input type="checkbox"/> in months
	Day	Month	Year	
6. Child's gender:	<input type="checkbox"/> 0 Boy	<input type="checkbox"/> 1 Girl	GENDER	
7. Have you been able to identify the child?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	ID_CHILD No Yes Died <i>[If "Yes", continue; otherwise stop, write your name and staff code, date the form and send to DCC.]</i>

Eligibility Checklist

8. Is this child appropriately age-matched to the index case?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9	AGE_MATCH
9. Is this child the same gender as the index case?	<input type="checkbox"/> 0	<input type="checkbox"/> 1		SAME_GEN
10. Does this child live in the same or nearby village or community as case?	<input type="checkbox"/> 0	<input type="checkbox"/> 1		SAME_VILLA
11. Was the index case enrolled within the past 14 days?	<input type="checkbox"/> 0	<input type="checkbox"/> 1		ENROLL_7
12. Has this child been free of diarrhea for the past 7 days?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9	DRH_FREE7
13. Is the child eligible for enrollment?	<input type="checkbox"/> 0	<input type="checkbox"/> 1		ELIG_ENROLL

(The child is eligible only if the answers to the Questions 8 through 12 are "Yes".)

13a. If either Questions 8 or 12 are "DK", check the option that best describes why you were not able to determine eligibility.

NOT_ELIG

1 Caretaker not available. 2 Other, specify NOT_ELIG_SPEC

(If not eligible, STOP, end the interview by thanking the caretaker/parent for their participation. Write down name and staff code, date the form and submit to DCC. If the child is eligible, continue to Question 14.)

Interviewer's Name	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	INT_CODE
		Staff code
Quality Control's Name	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	QC_CODE
		Staff code
		Day
		Month
		Year
VRG Updated 22Aug2011	20	



Study # 004

Plate # 062

Visit # 001

Site

Center

Child ID (Control)

No Yes

14. Was consent obtained? 0 1 CONSENT

15. Was a stool sample collected from the child? 0 1 STOOL_SMPL

16. Was the child enrolled? 0 1 ENROLLED

17. If eligible but not enrolled, what was the reason? [*"X" one of the two main reasons.*]

NOT_ENROLL

1 Not invited for one of the following reasons:

NOT_INVITE 1 Unable to produce adequate stool sample [*10 grams with a minimum of 3 grams*]
 2 Other, specify NO_INVITE_SPEC

2 Refused by parent/caretaker for one of the following reasons:

REFUSED 1 Parent/caretaker too busy
 2 Does not like research
 3 Other, specify REFUSED_SPEC

DATE_ENROLL

18. If child is enrolled into the study, enter the date of enrollment:

Day

Month

Year

Notes or comments [*Initial and date notes.*]

Interviewer's Name _____

INT_CODE2

Staff code

Quality Control's Name _____

QC_CODE2

QC_DATE2

Staff code

Day

Month

Year

Study # 004	CHIL DID	Plate # 071	Visit # 001	F7_DATE
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Site	Center	Control ID	Day	Month
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> CASE_ID				
Index Case ID				

Section 1: Demographic and Epidemiological Information

1. Who is [Child's Name]'s primary caretaker? PRIMCARE

<input type="checkbox"/> 1 Mother	<input type="checkbox"/> 2 Father	<input type="checkbox"/> 3 Sister	<input type="checkbox"/> 4 Brother
<input type="checkbox"/> 5 Grandmother	<input type="checkbox"/> 6 Grandfather	<input type="checkbox"/> 7 Aunt	<input type="checkbox"/> 8 Uncle
<input type="checkbox"/> 9 No relation	<input type="checkbox"/> 10 Other relation by blood or marriage, specify _____	PRIMCARE_SPEC	

2. What is your relationship to [Child's Name]? RELATION

<input type="checkbox"/> 1 Mother	<input type="checkbox"/> 2 Father	<input type="checkbox"/> 3 Sister	<input type="checkbox"/> 4 Brother
<input type="checkbox"/> 5 Grandmother	<input type="checkbox"/> 6 Grandfather	<input type="checkbox"/> 7 Aunt	<input type="checkbox"/> 8 Uncle
<input type="checkbox"/> 9 No relation	<input type="checkbox"/> 10 Other relation by blood or marriage, specify _____	RELATION_SPEC	

3. Where does [Child's Name]'s mother live? MOM_LIVE

<input type="checkbox"/> 1 Living in household	<input type="checkbox"/> 3 Abroad	<input type="checkbox"/> 5 Died
<input type="checkbox"/> 2 Lives outside of household	<input type="checkbox"/> 4 Whereabouts unknown	

4. Where does [Child's Name]'s father live? DAD_LIVE

<input type="checkbox"/> 1 Living in household	<input type="checkbox"/> 2 Abroad	<input type="checkbox"/> 3 Died
<input type="checkbox"/> 4 Lives outside of household	<input type="checkbox"/> 5 Whereabouts unknown	

5. How far did the child's primary caretaker go in school?

<input type="checkbox"/> 1 No formal schooling	<input type="checkbox"/> 4 Completed secondary
<input type="checkbox"/> 2 Less than primary	<input type="checkbox"/> 5 Post-secondary
<input type="checkbox"/> 3 Completed primary	<input type="checkbox"/> 6 Religious education only
	<input type="checkbox"/> 7 Don't know

PPL_HOUSE

6. How many people have been living regularly in your household for the past 6 months?

<input type="text"/>	<input type="text"/>
----------------------	----------------------

PPL_SLEEP

7. How many people have been sleeping regularly in your household for the past 6 months?

<input type="text"/>	<input type="text"/>
----------------------	----------------------



Study # 004

Plate # 072

Visit # 001

Site

Center

Control ID

8. How many children younger than 60 months live in the household? YNG_CHILDREN9. How many rooms in your household are used for sleeping? SLP_ROOMS10. What is the predominant floor in the house of [Child's Name]? FLOORNatural FloorRudimentary FloorFinished Floor 1 Earth/Sand 3 Wood planks 5 Parquet or polished wood 2 Dung 4 Palm/bamboo 6 Vinyl or asphalt strips 7 Ceramic Tile 8 Cement 9 Carpet 10 Other, specify FLOOR_SPEC

11. Does your household have the following? [Must be functioning; "X" all that apply.]

 1 Electricity HOUSE_ELEC 1 Bicycle/rickshaw HOUSE_BIKE 1 Telephone (mobile or non-mobile) HOUSE_PHONE 1 Television HOUSE_TELE 1 Car/truck HOUSE_CAR 1 Animal-drawn cart HOUSE_CART 1 Motorcycle/scooter HOUSE_SCOOT 1 Refrigerator HOUSE_FRIDGE 1 Agricultural land HOUSE_AGLAND 1 Radio HOUSE_RADIO 1 Boat with a motor HOUSE_BOAT 1 None of the above HOUSE_NONE

12. What type of cooking fuel does your household use? [“X” all that apply.]

 1 Electricity FUEL_ELEC 1 Biogas FUEL_BIOGAS 1 Straw/shrubs/grass FUEL_GRASS 1 Liquid Propane Gas FUEL_PROPANE 1 Coal/lignite FUEL_COAL 1 Animal dung FUEL_DUNG 1 Natural Gas FUEL_NATGAS 1 Charcoal FUEL_CHARCOAL 1 Agricultural crop residue FUEL_CROP 1 Kerosene FUEL_KERO 1 Wood FUEL_WOOD 1 Other, specify FUEL_OTHER FUEL_OTHER_SPEC

Study # 004	Plate # 073	Visit # 001
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Site	Center	Control ID

13. Do the following animals live in the compound where *[Child's Name]* lives? [*"X" all that apply.*]

ANI_GOAT <input type="checkbox"/> 1 Goat	ANI_COW <input type="checkbox"/> 1 Cow	ANI_NO <input type="checkbox"/> 1 No Animals
ANI_SHEEP <input type="checkbox"/> 1 Sheep	ANI_RODENTS <input type="checkbox"/> 1 Rodents	
ANI_DOG <input type="checkbox"/> 1 Dog	ANI_FOWL <input type="checkbox"/> 1 Fowl (chicken, duck or other birds)	
ANI_CAT <input type="checkbox"/> 1 Cat	ANI_OTHER <input type="checkbox"/> 1 Other, specify <u>ANI_SPEC</u>	

14. During the last two weeks, has your household ever obtained drinking water from any of the following sources? [*"X" all that apply.*]

<input type="checkbox"/> 1 Piped into house <u>WATER_HOUSE</u>	<input type="checkbox"/> 1 Covered well in house or yard <u>WATER_COVWELL</u>
<input type="checkbox"/> 1 Piped into yard <u>WATER_YARD</u>	<input type="checkbox"/> 1 Covered public well <u>WATER_COVPWELL</u>
<input type="checkbox"/> 1 Public tap <u>WATER_PUBTAP</u>	<input type="checkbox"/> 1 Protected spring <u>WATER_PROSPRING</u>
<input type="checkbox"/> 1 Open well in house or yard <u>WATER_WELL</u>	<input type="checkbox"/> 1 Unprotected spring <u>WATER_UNSPRING</u>
<input type="checkbox"/> 1 Open public well <u>WATER_PUBWELL</u>	<input type="checkbox"/> 1 River or stream <u>WATER_RIVER</u>
<input type="checkbox"/> 1 Pond or lake <u>WATER_POND</u>	<input type="checkbox"/> 1 Dam or earth pan <u>WATER_DAM</u>
<input type="checkbox"/> 1 Deep tube well <u>WATER_DEEPWELL</u>	<input type="checkbox"/> 1 Rainwater <u>WATER_RAIN</u>
<input type="checkbox"/> 1 Shallow tube well <u>WATER_SHALLWELL</u>	<input type="checkbox"/> 1 Bought (tank, bottles, etc) <u>WATER_BOUGHT</u>
<input type="checkbox"/> 1 Other, specify <u>WATER_OTHR</u> <u>WATER_SPEC</u>	<input type="checkbox"/> 1 Bore hole <u>WATER_BORE</u>

15. During the last two weeks, what was the **main source** of drinking water for the members of your household? [*"X" only one response that relates to the main source of drinking water.*]

MS_WATER

<input type="checkbox"/> 1 Piped into house	<input type="checkbox"/> 9 Covered well in house or yard
<input type="checkbox"/> 2 Piped into yard	<input type="checkbox"/> 10 Covered public well
<input type="checkbox"/> 3 Public tap	<input type="checkbox"/> 11 Protected spring
<input type="checkbox"/> 4 Open well in house or yard	<input type="checkbox"/> 12 Unprotected spring
<input type="checkbox"/> 5 Open public well	<input type="checkbox"/> 13 River or stream
<input type="checkbox"/> 6 Pond or lake	<input type="checkbox"/> 14 Dam or earth pan
<input type="checkbox"/> 7 Deep tube well	<input type="checkbox"/> 15 Rainwater
<input type="checkbox"/> 8 Shallow tube well	<input type="checkbox"/> 16 Bought (tank, bottles, etc)
<input type="checkbox"/> 18 Other, specify <u>MS_SPEC</u>	<input type="checkbox"/> 17 Bore hole

[Use your response from Question 15 to answer Questions 16 and 17. If the response to Question 15 is "piped into house/yard", "open or covered well in house/yard" or "rainwater", then go to Question 18. Otherwise continue.]

Study # 004	Plate # 074	Visit # 001
<input type="text"/>	<input type="text"/>	<input type="text"/>
Site	Center	Control ID

16. How long does it take to go there, get water, and come back?

TIME_WATER

<input type="checkbox"/> 1 Less than 15 minutes	<input type="checkbox"/> 4 1 to 3 hours
<input type="checkbox"/> 2 15 to 29 minutes	<input type="checkbox"/> 5 More than 3 hours
<input type="checkbox"/> 3 30 to 59 minutes	

17. Do you or other members from your household go and fetch drinking water for the household every day?

[If "Yes", go to Question 17a, if "No" go to Question 17b.]

No Yes

FETCH_WATER 0 1

Number of trips/day

TRIP_DAY

17a. On average, how many trips do you and members from your household make to fetch water each day?

17b. On average, how many trips do you and members from your household make to fetch water each week?

[If no trips are made, complete as "00".]

Number of trips/week

TRIP_WEEK

18. In the last two weeks, how often has water been available from this main source?

<input type="checkbox"/> 1 All the time	<input type="checkbox"/> 3 A few times per week	WATER_AVAIL
<input type="checkbox"/> 2 Several hours everyday	<input type="checkbox"/> 4 Less frequent than a few times per week	

19. In the last two weeks, did you give *[Child's Name]* stored water for drinking?

STORE_WATER 0 1

No Yes

20. Do you usually treat drinking water at home?

[If "No", go to Question 23.]

TRT_WATER 0 1

21. Which method do you use the most to treat drinking water at home? *[X only one response.]*

TRT_METHOD

<input type="checkbox"/> 1 Leave water in sun to disinfect	<input type="checkbox"/> 4 Boil
<input type="checkbox"/> 2 Filter through a cloth	<input type="checkbox"/> 5 Filter through ceramic or other filter
<input type="checkbox"/> 3 Chlorine liquid, powder, or tablets	<input type="checkbox"/> 6 Alum
<input type="checkbox"/> 7 Other chemical or additive, specify <u>TRT_METHOD_SPEC</u>	

[If chlorine is not used, go to Question 22]

21a. If you use chlorine liquid, powder or tablets, which type do you most commonly use? *[X only one response.]* **CHLORINE**

<input type="checkbox"/> 1 Certeza	<input type="checkbox"/> 5 Watermaker
<input type="checkbox"/> 2 Aquatabs	<input type="checkbox"/> 6 PurR
<input type="checkbox"/> 3 AquaGuard	<input type="checkbox"/> 7 Don't know
<input type="checkbox"/> 4 WaterGuard	<input type="checkbox"/> 8 Other, specify <u>CHLORINE_SPEC</u>



Study # 004

Plate # 075

Visit # 001

Site

Center

Control ID

NOTRT_WATER No Yes

22. In the last two weeks did you give [Child's Name] water which was not treated?

23. How do you usually dispose of [Child's Name]'s feces? [“X” only one response.]

DISP_FECES

<input type="text" value="1"/> Scatter in yard	<input type="text" value="4"/> Bush/Field/Ground/Stream/Open sewer
<input type="text" value="2"/> Bury	<input type="text" value="5"/> Do nothing
<input type="text" value="3"/> Toilet, latrine	<input type="text" value="6"/> Other, specify <u>DISP_SPEC</u>

24. What kind of facility does your household most commonly use to dispose of human fecal waste?

[Show pictures to confirm the identity of the facility used. “X” only one response.]

FAC_WASTE

<input type="text" value="1"/> Flush toilet	<input type="text" value="4"/> Pour flush toilet
<input type="text" value="2"/> Ventilated improved pit (VIP) latrine	<input type="text" value="5"/> No facility: Bush/Field/Ground/Stream/Open sewer
<input type="text" value="3"/> Traditional pit toilet	<i>[If “No facility” selected, go to Question 26.]</i>
<input type="text" value="7"/> Ventilated improved pit w/water seal	<input type="text" value="6"/> Other, specify <u>FAC_SPEC</u>

25. How many households (other than your own) share this facility? SHARE_FAC

[Respond with a number; code “00” for none.]

26. When do you usually wash your hands? [“X” all that apply. Do not probe.]

<input type="text" value="1"/> Before eating <u>WASH_EAT</u>	<input type="text" value="2"/> WASH_ANIMAL	<input type="text" value="1"/> After handling domestic animals
<input type="text" value="1"/> Before cooking <u>WASH_COOK</u>	<input type="text" value="2"/> WASH_CHILD	<input type="text" value="1"/> After cleaning child who defecated
<input type="text" value="1"/> Before you nurse or prepare baby's food <u>WASH_NURSE</u>	<input type="text" value="2"/> WASH_NEVER	<input type="text" value="1"/> Never
<input type="text" value="1"/> After you defecate <u>WASH_DEF</u>	<input type="text" value="2"/> WASH_OTHR	<input type="text" value="1"/> Other, specify <u>WASH_SPEC</u>

27. When you wash your hands, what do you usually use? [“X” only one.] WASH_USE

<input type="text" value="1"/> Water only	<input type="text" value="2"/> Water and soap	<input type="text" value="3"/> Water and ashes	<input type="text" value="4"/> Water and mud or clay
---	---	--	--

Section 2: Clinical Information

28. Is [Child's Name] currently breastfed? BREASTFED

<input type="text" value="0"/> No	<input type="text" value="1"/> Partial breastfeeding	<input type="text" value="2"/> Exclusive breastfeeding
-----------------------------------	--	--

Study # 004	Plate # 076	Visit # 001
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Site	Center	Control ID

29. During the last 7 days, did [Child's Name] have any of the following?

	No	Yes
a. Blood in stools	<input type="checkbox"/> 0	<input type="checkbox"/> 1 BLOOD
b. Fever measured at least 38 °C or parental perception	<input type="checkbox"/> 0	<input type="checkbox"/> 1 FEVER
c. Vomiting 3 or more times per day	<input type="checkbox"/> 0	<input type="checkbox"/> 1 VOMIT

30. Is the child currently receiving any medicine?

[If "No", go to Question 31.]

30a. If 'Yes' to Question 30, is a bottle or tablet strip or prescription available for ongoing treatment?

[If "Yes", go to Question 30b.]

No	Yes
<input type="checkbox"/> 0	<input type="checkbox"/> 1 CUR_MED

30b. What are the medicines that the child is currently receiving? [*"X" all that apply.*]

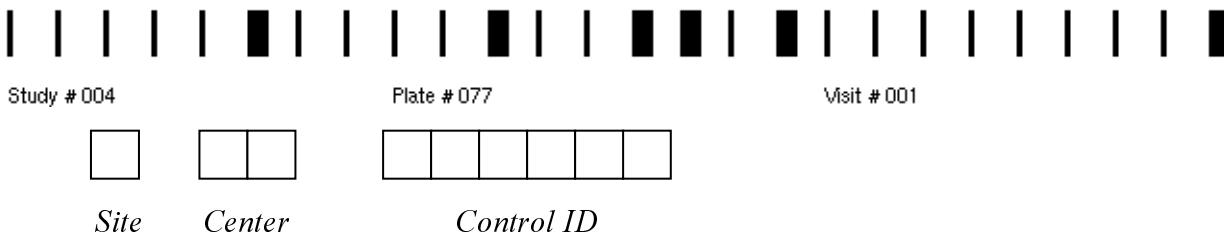
MED_ORS	<input type="checkbox"/> 1 ORS	<input type="checkbox"/> 1 Ampicillin	MED_AMPI
MED_IV	<input type="checkbox"/> 1 Intravenous fluids	<input type="checkbox"/> 1 Nalidixic acid	MED_NALID
MED_COTR	<input type="checkbox"/> 1 Cotrimoxazole	<input type="checkbox"/> 1 Ciprofloxacin/Norfloxacin/other fluoroquinolone	MED_CIPRO
MED_NOFOOD	<input type="checkbox"/> 1 Normal food withheld for \geq 1 day	<input type="checkbox"/> 1 Selexid/Pivmecillinam	MED_SELE
MED_GENT	<input type="checkbox"/> 1 Gentamycin	<input type="checkbox"/> 1 Other antibiotic, specify _____	MED_OTHERANT
MED_CHLOR	<input type="checkbox"/> 1 Chloramphenicol/Thiamphenicol	<input type="checkbox"/> 1 Zinc	MED_ZINC
MED_ERYTH	<input type="checkbox"/> 1 Erythromycin	<input type="checkbox"/> 1 A (government recommended) homemade fluid	MED_GOVFLUID
MED_AZITH	<input type="checkbox"/> 1 Azithromycin	<input type="checkbox"/> 1 An antimalarial drug	MED_ANTIMAL
MED_OMACR	<input type="checkbox"/> 1 Other macrolides	<input type="checkbox"/> 1 Other medicine, specify _____	MED_OTHER1
MED_PENI	<input type="checkbox"/> 1 Penicillin	<input type="checkbox"/> 1 Other medicine, specify _____	MED_OTHER2
MED_AMOXY	<input type="checkbox"/> 1 Amoxycillin	<input type="checkbox"/> 1 Other medicine, specify _____	MED_OTHER3
	<input type="checkbox"/> 1 Nothing	<input type="checkbox"/> 1 Other medicine, specify _____	MED_NONE

31. The last time [Child's Name] had diarrhea, did you seek care for him/her outside your household?

[If "No", go to Question 33.]

If the child never had diarrhea, go to Question 35.]

No	Yes	Never had diarrhea	
SEEKCARE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2



32. If you sought care for [Child's Name]'s last episode of diarrhea where did you go? [Use the Health Facility Coding List to code the center(s) of choice. "X" all that apply.]

Pharmacy SEEK_PHARM

Friend/relative SEEK_FRIEND

Traditional healer SEEK_HEALER

Unlicensed practitioner/village doctor/bush doctor/village health worker SEEK_DOC

Licensed practitioner/private doctor (not at hospital) SEEK_PRIVDOC

Bought a remedy/medicine at the shop/market, specify remedy/drug SEEK_REMDY SEEK_REMDY_SPEC

Hospital/Center of first choice SEEK_CTR1 SEEK_CTR1_CODE SEEK_CTR1_SHC 1=SHC, 0_NonSHC

Hospital/Center of second choice SEEK_CTR2 SEEK_CTR2_CODE SEEK_CTR2_SHC 1=SHC, 0_NonSHC

Hospital/Center of third choice SEEK_CTR3 SEEK_CTR3_CODE SEEK_CTR3_SHC 1=SHC, 0_NonSHC

Other Hospital/Center, specify SEEK_OTHR SEEK_OTHR_SPEC

33. The last time [Child's name] had diarrhea, how much did you offer [Child's name] to drink?

OFFR_DRINK

<input type="checkbox"/> 1 More than usual	<input type="checkbox"/> 4 Much less than usual
<input type="checkbox"/> 2 Usual	<input type="checkbox"/> 5 Nothing to drink
<input type="checkbox"/> 3 Somewhat less than usual	

34. The last time [Child's Name] had diarrhea, how much did you offer [Child's Name] to eat?

OFFR_EAT

<input type="checkbox"/> 1 More than usual	<input type="checkbox"/> 4 Much less than usual
<input type="checkbox"/> 2 Usual	<input type="checkbox"/> 5 Nothing to eat
<input type="checkbox"/> 3 Somewhat less than usual	

Section 3: Physical Findings

35. Physical findings:

a Weight

0-23 months old: (Weight of caretaker with and without child):

WT_CHILD

WT_CARE

kg

Caretaker + child

Caretaker alone

24-59 months old: (Weight of child alone): **WT**

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 .

--

 kg



Study # 004

Plate # 078

Visit # 001

Site

Center

Control ID

HEIGHT

b. Height

HT1

1st

HT2

2nd

HT3

3rd

cm

cm

cm

MUAC

c. MUAC

MUAC1

1st

MUAC2

2nd

MUAC3

3rd

cm

cm

cm

d. Axillary temperature

TEMP

°C

RESP

e. Respiratory rate per minute

RESP1

1st

RESP2

2nd

Absent

Present

f. Bipedal edema [Both feet]

BIPEDAL

g. Abnormal hair: sparse, loose, straight

ABN_HAIR

h. Undernutrition: wasted/very thin

UNDER_NUTR

i. Skin has 'flaky paint' appearance

SKIN_FLAKY

END OF INTERVIEW

THANK RESPONDENT(S) FOR THEIR COOPERATION

36. Specimen ID:

SPECIMEN_ID

Place sticker of Specimen ID here.

Notes or comments [Initial and date notes]

Interviewer's Name _____

INT_CODE

Staff code

QC_DATE

Quality Control's Name _____

QC_CODE

Staff code

Day

Month

Year

Study # 004	CHIL DID	Plate # 091	Visit # 002	F9_DATE
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Site	Center	Child ID	Day	Month
				Year

No Yes Partial

1. Was the Memory Aid completed? **MEMORY_AID**

[If "No", "X" and sign the form and hand over to supervisor.]

2. If "Yes" or "Partial", what was the first and last day of diarrhea according to the Memory Aid?

First day of Diarrhea: **DRH_FIRST**

Last day of Diarrhea: **DRH_LAST**

[Code 1 to 14 from Memory Aid, Column 1]

Notes or comments *[Add date and initials or staff code]*

Interviewer's Name _____

INT_CODE

Staff code

Quality Control's Name _____

QC_CODE

Staff code

QC_DATE

Day

Month

Year

Study # 004	CHIL DID	Plate # 113	Visit # 001	F11_DATE	
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 0 <input type="checkbox"/> <input type="checkbox"/>	
Site	Center	Child ID	Day	Month	Year

1. Time and date when whole stool passed/excreted: Version **3**
VERSION #

a. Date first whole stool passed/excreted: **DATESOOL** 2 0
Day Month Year

b. Time first whole stool passed/excreted: **TIMESTOOL** (24 hour clock)

2. Consistency of whole stool sample: (select one)

CONSISTENCY

<input type="checkbox"/> grade 1 (formed)	<input type="checkbox"/> grade 2 (soft)	<input type="checkbox"/> grade 3 (thick liquid)
<input type="checkbox"/> grade 4 (opaque watery)	<input type="checkbox"/> grade 5 (rice water-clear watery)	

3. Characterization of whole stool sample:

PUS

Blood No Yes **Pus** No Yes **Mucus** No Yes
BLOOD

MUCUS

4. If the child is a case, did s/he receive antibiotics after arriving at the health center but before producing the whole stool specimen? If the child is a control, did s/he receive antibiotic during the 4 hours prior to stool collection?

ANTIBIOTIC

No Yes DK

[If 'Yes', check the appropriate boxes ("X" all that apply). If 'No', go to Question 7.]

ANTI_AMPI <input type="checkbox"/> Ampicillin	ANTI_NALI <input type="checkbox"/> Nalidixic acid
ANTI_COTR <input type="checkbox"/> Cotrimoxazole	ANTI_CIPR <input type="checkbox"/> Ciprofloxacin/Norfloxacin/other fluoroquinolone
ANTI_SELE <input type="checkbox"/> Selexid/Pivmecillinam	ANTI_GENT <input type="checkbox"/> Gentamycin
ANTI_CHLO <input type="checkbox"/> Chloramphenicol/Thiamphenicol	ANTI_ERYT <input type="checkbox"/> Erythromycin
ANTI_AZIT <input type="checkbox"/> Azithromycin	ANTI_MACR <input type="checkbox"/> Other macrolides
ANTI_PENI <input type="checkbox"/> Penicillin	ANTI_OTHER <input type="checkbox"/> Other antibiotic, specify _____ ANTI_SPEC
ANTI_AMOX <input type="checkbox"/> Amoxycillin	

5. If antibiotic was given:

a. Date of first antibiotic: 2 0 **ANTI_DATE**
Day Month Year

b. Time of first antibiotic: (24 hour clock) **ANTI_TIME**

Study # 004	Plate # 114	Visit # 001
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Site	Center	Child ID

6. If the child is a **case** and *was given antibiotics* at the health center **before** the child produced a *whole stool specimen*, were rectal swabs collected from the child before the child received antibiotics?

RECTAL_SWAB 0 No 1 Yes *[If 'Yes', continue. If 'No', go to Question 7.]*

a. Date rectal swabs obtained:

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

2	0	<input type="checkbox"/>
---	---	--------------------------

 SWAB_DATE
Day Month Year

b. Time rectal swabs obtained:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

 (24 hour clock) SWAB_TIME

7. Time and date when whole stool/rectal swab placed in transport media: DATESTAFF

a. Date whole stool/rectal swab placed in transport media:

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

2	0	<input type="checkbox"/>
---	---	--------------------------

 TIMESTAFF
Day Month Year

b. Time whole stool/rectal swab placed in transport media:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

 (24 hour clock)

8. Swab (rectal swab/whole stool) in Cary Blair: 0 No 1 Yes CARYBLAIR

9. Swab (rectal swab/whole stool) in Buffered Glycerol Saline: 0 No 1 Yes GLYCEROL
SPECIMEN_ID

10. Specimen ID:

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Place sticker of Specimen ID here.

11. Time and date when sample received by lab personnel:

SPECIMEN_LABDATE

a. Date sample received by lab personnel:

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

2	0	<input type="checkbox"/>
---	---	--------------------------

Day Month Year

b. Time sample received by lab personnel:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

 (24 hour clock)

SPECIMEN_LABTIME

Interviewer's Name _____

INT_CODE

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff code		

QC_DATE

Quality Control's Name _____

QC_CODE

<input type="checkbox"/>	<input type="checkbox"/>
Staff code	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day	Month	Year

2	0	<input type="checkbox"/>
Year	Month	Day

VRG Updated 22Aug2011

Study # 004

Plate # 151

Visit # 001

SPECIMEN_ID

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Specimen ID

COLLECT_RECT

2

VERSION

Version #

Rectal swab sample collected? 0 No 1 Yes Whole stool sample collected? 0 No 1 Yes

Specimen receipt:

Time processed in laboratory (24 hour clock)

--	--	--	--

TEST_TIME

Date

--	--

--	--	--

2	0		
---	---	--	--

Day

Month

Year

TEST_DATE

Properly labeled?

 0 No 1 Yes **LABLED**

Container tightly shut?

 0 No 1 Yes **TIGHTSHUT**

Temperature okay (cold pack frozen)?

 0 No 1 Yes **COLD** **WT_VOL_ACT**

Sufficient weight/volume (minimum 3 g/ml)?

 0 No 1 Yes Actual weight:

--	--

 .

--	--

 g

Acceptable for accession?

 0 No 1 Yes **ACCEPTABLE**

Aliquoted for:

VIRUSES	Viruses	<input type="checkbox"/> 0 No	<input checked="" type="checkbox"/> 1 Yes	PARASITES	Parasites	<input type="checkbox"/> 0 No	<input checked="" type="checkbox"/> 1 Yes
ARCHIVE1	Archive 1	<input type="checkbox"/> 0 No	<input checked="" type="checkbox"/> 1 Yes	ARCHIVE2	Archive 2	<input type="checkbox"/> 0 No	<input checked="" type="checkbox"/> 1 Yes

Specimen plated on:

XLD	TCBS	CAMPY			
SS/XLD	<input type="checkbox"/> 0 No <input checked="" type="checkbox"/> 1 Yes	TTGA/TCBS	<input type="checkbox"/> 0 No <input checked="" type="checkbox"/> 1 Yes	RYAN	<input type="checkbox"/> 0 No <input checked="" type="checkbox"/> 1 Yes
MaC MAC	<input type="checkbox"/> 0 No <input checked="" type="checkbox"/> 1 Yes	APW	<input type="checkbox"/> 0 No <input checked="" type="checkbox"/> 1 Yes	ABA/CIN/RYAN	<input type="checkbox"/> 0 No <input checked="" type="checkbox"/> 1 Yes
SFB SFB	<input type="checkbox"/> 0 No <input checked="" type="checkbox"/> 1 Yes	BP/APW			

Technician: _____

TECH_SIG

TECH_DATE

--	--	--	--

2

0

Day

Month

Year

QC/Supervisor: _____

QC_SIG

REVIEW_DATE Date Reviewed

--	--	--	--

2

0

Day

Month

Year



Specimen ID

Day

Month

Year

VERSION #

VERSION

Bacteria Isolated

<input type="checkbox"/> <i>Aeromonas</i> spp.	AEROMONAS														
<input type="checkbox"/> <i>Campylobacter jejuni</i>	CAMPY_JEJUNI														
<input type="checkbox"/> <i>Campylobacter coli</i>	CAMPY_COLI														
<input type="checkbox"/> <i>Campylobacter</i> (not <i>jejuni</i> or <i>coli</i>)	CAMPY_NONJEJ														
<input type="checkbox"/> <i>Campylobacter</i> (non-speciated)	CAMPY_NONSPEC														
<input type="checkbox"/> <i>Salmonella</i> Typhi	SALM_TYPHI														
	SALM_NONTYPHI														
<input type="checkbox"/> <i>Salmonella enterica</i> non-Typhi serovar	S_DYSENT	S_FLEXNERI	S_BOYDII	S SONNEI	S_NONTYPE										
SHIG_SPP	<i>S. dysenteriae</i>	<i>S. flexneri</i>	<i>S. boydii</i>	<i>S. sonnei</i>	Non-typeable										
<input type="checkbox"/> <i>Shigella</i> spp. Serogroup	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>	<input type="checkbox"/>										
<input type="checkbox"/> <i>Shigella dysenteriae</i> 1	SHIG_DYSENT1	SHIG_1A_1B_2A_2B_3A_3B_4A_4B_4C_5A_5B_6_X_Y			SHIG_NONTYP										
Shigella flexneri serotypes	1a	1b	2a	2b	3a	3b	4a	4b	4c	5a	5b	6	X	Y	Non-typeable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIB_CHOLERAE

VIB_01

VIB_0139

VIB_NON

Vibrio cholerae

01 0139 Non O1/NonO139

VIB_INABA

Inaba

VIB_OGAWA

Ogawa

Vibrio parahaemolyticus

VIB_PARAHAEM

Vibrio (other species)

VIB_OTHER

None of the above pathogens isolated

NONEPATHOS

E. coli isolated

ECOLI

No growth

NOGROWTH

TECH_DATE

Technician: _____ TECH_SIG 1=Signature present2 0

Day

Month

Year

REVIEW_DATE Date Reviewed

QC/Supervisor: _____ QC_SIG 1=Signature present2 0

Day

Month

Year

Study # 004 Plate # 171 Visit # 001

SPECIMEN_ID

Specimen ID

TEST_DATE *Date of Test*

Day *Month* *Year*

Results

<i>estA</i> (ST) (approx. 147 bp)	<input checked="" type="checkbox"/> <i>Positive</i>	<input type="checkbox"/> <i>Negative</i>	RESULT_ESTA
<i>eltB</i> (LT) (approx. 508 bp)	<input checked="" type="checkbox"/> <i>Positive</i>	<input type="checkbox"/> <i>Negative</i>	RESULT_ELTB
<i>bfpA</i> (approx. 367 bp)	<input checked="" type="checkbox"/> <i>Positive</i>	<input type="checkbox"/> <i>Negative</i>	RESULT_BFPA
<i>aatA</i> (approx. 630 bp)	<input checked="" type="checkbox"/> <i>Positive</i>	<input type="checkbox"/> <i>Negative</i>	RESULT_AATA
<i>aaiC</i> (approx. 215 bp)	<input checked="" type="checkbox"/> <i>Positive</i>	<input type="checkbox"/> <i>Negative</i>	RESULT_AAIC
<i>eae</i> (approx. 881 bp)	<input checked="" type="checkbox"/> <i>Positive</i>	<input type="checkbox"/> <i>Negative</i>	RESULT_EAE

E. coli ID (more than one may apply)

Internal Use Only

- eae*⁺ **only**
- bfpA*⁺ (with or without *eae*): Typical EPEC
- ETEC ST⁺ **only**
- ETEC ST⁺/LT⁺
- ETEC LT⁺ **only**
- EAEC *aatA*⁺ **only**
- EAEC *aaiC*⁺ **only**
- EAEC *aatA/aaiC*⁺
- Negative for diarrheagenic *E.coli*

Technician: _____ **TECH_SIG** 1=Signature present

TECH_DATE

Day *Month* *Year*

QC/Supervisor: _____ **QC_SIG** 1=Signature present

REVIEW_DATE *Date Reviewed*

Day *Month* *Year*

Study # 004	Plate # 175	Visit # 001					
SPECIMEN_ID		TEST_DATE					
<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>							<i>Date of Test</i>
<i>Specimen ID</i>		<i>Day</i> <i>Month</i> <i>Year</i>					

Results

Stx-2 (approx. 443 bp) 1 *Positive* 0 *Negative* **STX**

eae (approx. 377 bp) *Positive* *Negative* **Internal use only**

Sen (approx. 310 bp) Positive Negative SEN

Stx-1 (approx. 220 bp) Positive Negative **STX1**

Efa-1 (approx. 165 bp) Positive Negative EFA1

Technician: TECH1010 Signature present

TECH_DATE

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Day *Month* *Year*

REVIEW_DATE *Date Reviewed*

QC/S : QC_SIG 1=Signature present

Date Reviewed

Three sets of empty boxes for drawing, each consisting of three horizontal lines.

Study # 004	Plate # 181	Visit # 001	TEST_DATE	Date of Test
SPECIMEN_ID				
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<i>Specimen ID</i>		<i>Day</i>	<i>Month</i>	<i>Year</i>

PROTOZOAL ELISA IMMUNOASSAY*Entamoeba histolytica***COMP_ENTAMOEBA** 1 *Test completed***RES_ENTAMOEBA** 1 *Positive* 0 *Negative**Giardia lamblia***COMP_GIARDIA** 1 *Test completed***RES_GIARDIA** 1 *Positive* 0 *Negative**Cryptosporidium* spp.**COMP_CRYPTOSPOR** 1 *Test completed***RES_CRYPTOSPOR** 1 *Positive* 0 *Negative*Technician: **TECH_SIG1**

1=Signature present

TECH_DATE1 *Day**Month**Year*VIRAL ELISA IMMUNOASSAY*Rotavirus***COMP_ROTAVIRUS** 1 *Test completed***RES_ROTAVIRUS** 1 *Positive* 0 *Negative**Adenovirus***COMP_ADENOVIRUS** 1 *Test completed***RES_ADENOVIRUS** 1 *Positive* 0 *Negative**Adenovirus 40/41***COMP_ADENO4041** 1 *Test completed***RES_ADENO4041** 1 *Positive* 0 *Negative* 3 *N/A*Technician: **TECH_SIG2** 1=Signature present**TECH_DATE2** *Day**Month**Year*QC/Supervisor: **QC_SIG** 1=Signature present**REVIEW_DATE** Date Reviewed *Day**Month**Year*



RT-PCR FOR VIRUSES

Norovirus GI (~330 bp) Positive Negative NORO_GI

Norovirus GII (~387 bp) 1 *Positive* 0 *Negative* NORO_GII

Sapovirus (~434 bp) Positive Negative SAPO_VIRUS

Astrovirus (~ 719 bp) Positive Negative ASTRO_VIRUS

Technician: TECH_SIG 1=Signature present

TECH_DATE

Day Month Year

QC/Supervisor: QC_SIG 1=Signature present

REVIEW_DATE *Date Reviewed*

<input type="text"/>				
<i>Day</i>	<i>Month</i>		<i>Year</i>	