

RESULTS: IMAGING

IMG

Patient Name		Project Patient ID [][][][][]	Visit Num. [][]
Form completed by [][][]	Date dd MMM yy [][] - [][][][] - [][]		

CHEST X-RAY			
Chest x-ray done <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of chest x-ray dd MMM yy [][] - [][][][] - [][]	Chest x-ray results, Check all that apply <input type="checkbox"/> None (NAD) <input type="checkbox"/> Mediastinal mass <input type="checkbox"/> Consolidation <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Other <input type="checkbox"/> Result lost	If other chest results, specify: <hr/> If Pleural effusion, select one <input type="checkbox"/> Right <input type="checkbox"/> Left If Pleural effusion, select one <input type="checkbox"/> Trace <input type="checkbox"/> Moderate <input type="checkbox"/> Large

ULTRASOUND			
Abdominal U/S done <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of U/S dd MMM yy [][] - [][][][] - [][]	Ultrasound results, Check all that apply <input type="checkbox"/> None (NAD) <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Ascites <input type="checkbox"/> Other <input type="checkbox"/> Result lost	If other U/S results, specify:

Tumor site(s)	### cm	by	### cm	Notes
1. _____	[][]	x	[][]	
2. _____	[][]	x	[][]	
3. _____	[][]	x	[][]	
4. _____	[][]	x	[][]	
5. _____	[][]	x	[][]	
6. _____	[][]	x	[][]	

For Data Entry Purposes Only	Data entered by [][][]	Date dd MMM yy [][] - [][][][] - [][]	Form ID IMG - [][][][][][][][]	Page 1 of 1
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RESULTS: HISTOPATHOLOGY

HIST

Patient Name		Project Patient ID [][][][]	Visit Num. [][]
Form completed by [][][]	Date dd MMM yy [][] - [][][] - [][]		

TISSUE BIOPSY			
Biopsy done <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Tissue Biopsy dd MMM yy [][] - [][][] - [][]	Surgery location <input type="checkbox"/> Mulago oral surgery <input type="checkbox"/> Mulago Radiology <input type="checkbox"/> other, specify: _____	Specimen body location <input type="checkbox"/> Jaw <input type="checkbox"/> Lymph node <input type="checkbox"/> Abdomen <input type="checkbox"/> Other, specify: _____
Type of biopsy performed: <input type="checkbox"/> Incisional <input type="checkbox"/> FNA <input type="checkbox"/> Excisional (remove all) <input type="checkbox"/> other, specify: _____ <input type="checkbox"/> U/S guided		Tissue sent to the following labs: <i>(check all that apply)</i> <input type="checkbox"/> Makerere Pathology <input type="checkbox"/> Lancet <input type="checkbox"/> SurgPath <input type="checkbox"/> LMK <input type="checkbox"/> Multi-systems <input type="checkbox"/> other, specify: _____ <input type="checkbox"/> Lancet	

PATHOLOGY RESULT #1	
Diagnosis <input type="checkbox"/> Burkitt Lymphoma <input type="checkbox"/> Lymphoblastic <input type="checkbox"/> Retinoblastoma <input type="checkbox"/> Rhabdomyosarcoma <input type="checkbox"/> Not cancer <input type="checkbox"/> Result lost <input type="checkbox"/> Other → <i>specify</i> _____	Pathology result #1 from the following lab: <input type="checkbox"/> Makerere Pathology <input type="checkbox"/> SurgPath <input type="checkbox"/> Lancet <input type="checkbox"/> LMK <input type="checkbox"/> Multi-systems <input type="checkbox"/> other → Lab name _____
Date lab received sample dd MMM yy [][] - [][][] - [][] <input type="checkbox"/> Unknown	Date of Result dd MMM yy [][] - [][][] - [][] <input type="checkbox"/> Unknown

PATHOLOGY RESULT #2	
Diagnosis <input type="checkbox"/> Burkitt Lymphoma <input type="checkbox"/> Lymphoblastic <input type="checkbox"/> Retinoblastoma <input type="checkbox"/> Rhabdomyosarcoma <input type="checkbox"/> Not cancer <input type="checkbox"/> Result lost <input type="checkbox"/> Other → <i>specify</i> _____	Pathology result #1 from the following lab: <input type="checkbox"/> Makerere Pathology <input type="checkbox"/> SurgPath <input type="checkbox"/> Lancet <input type="checkbox"/> LMK <input type="checkbox"/> Multi-systems <input type="checkbox"/> other → Lab name _____
Date lab received sample dd MMM yy [][] - [][][] - [][] <input type="checkbox"/> Unknown	Date of Result dd MMM yy [][] - [][][] - [][] <input type="checkbox"/> Unknown

PATHOLOGY RESULT #3	
Diagnosis <input type="checkbox"/> Burkitt Lymphoma <input type="checkbox"/> Lymphoblastic <input type="checkbox"/> Retinoblastoma <input type="checkbox"/> Rhabdomyosarcoma <input type="checkbox"/> Not cancer <input type="checkbox"/> Result lost <input type="checkbox"/> Other → <i>specify</i> _____	Pathology result #1 from the following lab: <input type="checkbox"/> Makerere Pathology <input type="checkbox"/> SurgPath <input type="checkbox"/> Lancet <input type="checkbox"/> LMK <input type="checkbox"/> Multi-systems <input type="checkbox"/> other → Lab name _____
Date lab received sample dd MMM yy [][] - [][][] - [][] <input type="checkbox"/> Unknown	Date of Result dd MMM yy [][] - [][][] - [][] <input type="checkbox"/> Unknown

IMMUNOHISTOCHEMISTRY							
Any IHC performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	CD45 <input type="checkbox"/> positive <input type="checkbox"/> negative	CD3 <input type="checkbox"/> positive <input type="checkbox"/> negative	CD20 <input type="checkbox"/> positive <input type="checkbox"/> negative	CD10 <input type="checkbox"/> positive <input type="checkbox"/> negative	Bcl-2 <input type="checkbox"/> positive <input type="checkbox"/> negative	Bcl-6 <input type="checkbox"/> positive <input type="checkbox"/> negative	Ki-67 result (%) [][][]
Other immunohistochemistry results 							

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NUTRITION

NU

Patient Name			Project Patient ID [][][][][]			Visit Num. [][]	
Form completed by [][][]		Date dd MMM yy [][] - [][][] - [][]					

NUTRITIONAL ASSESSMENT				
Weight (kg) [][] . []	Height/length (cm) [][][] . []	BMI (kg/m ²) [][] . []	MUAC (cm), first [][] . []	MUAC (cm), second [][] . []
Oedema status <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not captured		Grade of Oedema (<i>select one</i>) <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> +4 <input type="checkbox"/> not captured		Feeding route <input type="checkbox"/> oral <input type="checkbox"/> NG tube
Weight for length/height z-score category (<i>select one</i>) <input type="checkbox"/> < -3 SD <input type="checkbox"/> -3 SD to -2 SD <input type="checkbox"/> > -2 SD <input type="checkbox"/> not assessed			Malnutrition status (<i>select one</i>) <input type="checkbox"/> SAM <input type="checkbox"/> MAM <input type="checkbox"/> healthy/fine <input type="checkbox"/> not assessed	

TREATMENT PLAN	
F75 or F100 <input type="checkbox"/> no <input type="checkbox"/> yes → <i>Complete F75/F100 Nutrition Plan below and discuss plan with Clinician</i> <input type="checkbox"/> not assessed	

F75/F100 NUTRITION PLAN					
Feed <small>(ex. F75)</small>	Dose (ml/kg/feed) <small>(ex. 100 ml)</small>	Frequency <small>(ex. 2-hourly)</small>	Start Date <small>(dd-MMM-yy)</small>	End Date <small>(dd-MMM-yy)</small>	Notes
1.					
2.					
3.					
4.					

Nutritional support notes

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DISCHARGE

DC

Patient Name		Project Patient ID [][][][][]	Visit Num. [][]
Form completed by [][][]	Date dd MMM yy [][] - [][][] - [][]		

INPATIENT SUMMARY

Was the patient kept as an inpatient? <input type="checkbox"/> yes <input type="checkbox"/> no	Reason patient kept as inpatient: <i>Check all that apply</i> <input type="checkbox"/> Diagnosis or Restaging work-up <input type="checkbox"/> Treatment regimen <input type="checkbox"/> Tumor Lysis Syndrome <input type="checkbox"/> Infection <input type="checkbox"/> Malnourished <input type="checkbox"/> other If other, specify _____	If infection, check all that apply: <input type="checkbox"/> pneumonia <input type="checkbox"/> febrile neutropenia <input type="checkbox"/> sepsis <input type="checkbox"/> gastroenteritis <input type="checkbox"/> malaria
Any delays to this visit caused by family/social issues <input type="checkbox"/> yes <input type="checkbox"/> no	Family/social reasons for delayed visit: <input type="checkbox"/> Money <input type="checkbox"/> Caretaker availability (sickness, work, etc.) <input type="checkbox"/> Other	Other reason for family/social delay:

CONTACT CHANGES

Any changes to parent/guardian status <input type="checkbox"/> yes <input type="checkbox"/> no	Instructions: document only the CHANGES to the contact information (new contacts and changes to contact information) Data entry: edit or enter new information in the ENR form.			
Name	Relation to patient	Parent Guardian Phone(s)		
1) _____	1) _____	1) [][][][] - [][][][][][][][] [][][][][] - [][][][][][][][]		
2) _____	2) _____	2) [][][][] - [][][][][][][][] [][][][][] - [][][][][][][][]		
3) _____	3) _____	3) [][][][] - [][][][][][][][] [][][][][] - [][][][][][][][]		
Does the patient have a place to stay in the Kampala area? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will the patient be able to stay with relatives/contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relative's/Contact's Name <input type="checkbox"/> N/A Relative's/Contact's Phone Number <input type="checkbox"/> N/A [][][][][] - [][][][][][][][]		
Does the primary caretaker have a phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the primary caretaker literate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will another household member receive or read the SMS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will an SMS be acceptable? <input type="checkbox"/> Yes <input type="checkbox"/> No	SMS language (select one) <input type="checkbox"/> English <input type="checkbox"/> Luganda
Contact name for SMS:		Phone Number for SMS [][][][][] - [][][][][][][][]		
Contact Notes				

For Data Entry Purposes Only	Data entered by [][][]	Date dd MMM yy [][] - [][][] - [][]	Form ID DC - [][][][][][][][]	Page 1 of 1
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EXIT

EX

Patient Name	Project Patient ID <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>					Visit Num. <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:50%;"></td> </tr> </table>		

EXIT INFORMATION							
Date of exit dd MMM yy <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>							
Reason for exit <input type="checkbox"/> completed follow-up <input type="checkbox"/> lost to follow-up <input type="checkbox"/> sent home → <i>complete section below</i> <input type="checkbox"/> death → <i>complete section below</i> <input type="checkbox"/> drop out → Reason _____ <input type="checkbox"/> transfer → Where _____ <input type="checkbox"/> no longer meets project criteria → New Diagnosis _____							
Exit notes							
Date Completed dd MMM yy <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>					Completed by <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:50%;"></td> </tr> </table>		

DEATH INFORMATION							
Date of death dd MMM yy <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>							
Cause of death (<i>select one</i>) <input type="checkbox"/> Tumor <input type="checkbox"/> Infection <input type="checkbox"/> Other <input type="checkbox"/> unknown	If Infection, specify	If other, specify:					
Cause of death notes:							
Date Completed dd MMM yy <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>					Completed by <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:50%;"></td> </tr> </table>		

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