

COMMUNICABLE DISEASE TOOLKIT

LIBERIA

2. HEALTH SURVEILLANCE FORMS



World Health Organization
Geneva

1. WEEKLY MORBIDITY FORM

County: District/Zone:

Community/Settlement/Camp:.....Health facility:.....

Agency:

Reporting period: From Monday/...../..... To Sunday/...../.....

Total population covered: Under-5 population:

DISEASE / SYNDROME	NEW CASES	
	Under 5 years	5 years and over
Acute watery diarrhoea (incl. suspected *cholera)		
Acute bloody diarrhoea (incl. suspected *shigellosis)		
* Acute flaccid paralysis (suspected poliomyelitis)		
* Acute haemorrhagic fever syndrome		
* Acute jaundice syndrome (including *yellow fever)		
* Measles		
* Meningitis – suspected		
* Neonatal tetanus		
Acute lower respiratory infection/pneumonia		
Malaria		
– suspected		
– confirmed (rapid test/smear)		
Fever of unknown origin		
Sexually transmitted infections		
Tuberculosis – suspected		
Severe malnutrition		
Trauma/injury		
Others		
TOTAL NUMBER OF CONSULTATIONS		

- Count new cases only.
- Count the primary disease/syndrome only.
- If no cases, write “0”.
- Review “Emergency Phase Surveillance System Liberia: Case Definitions”.

* Report these diseases and any cases of suspected cholera or suspected shigellosis immediately to your health coordinator or field surveillance officer using **CASE-BASED REPORTING FORM**. Alert thresholds for other diseases/syndromes are provided in WHO “Emergency Phase Surveillance System Liberia: Guidelines For Use of Health Surveillance Forms”.

For use by data management office

Form received: ___/___/___ Validated Entered Record number: _____

3. CASE-BASED REPORTING FORM FOR EMERGENCY PHASE

County _____
 Reporting health facility _____
 Reporting district _____

Suspected disease (tick):

Acute flaccid paralysis	Cholera	Bloody diarrhoea/shigellosis	Neonatal tetanus (NT)	Measles	Meningitis	Lassa fever	Yellow fever

____/____/____
 dd mm yyyy
 Form received at central level

Name(s) of patient: _____ Date of birth: ____/____/____ Age: ____ years ____ months ____ days
(If <12 months) (NNT only)

Patient's residence: Village/neighbourhood _____ Sex: ____ M = male F = female

Town/City: _____ County: _____ Urban/rural: ____ U = urban R = rural

Locating information: _____
If applicable, name of mother and father of neonate or child

Date seen at health facility: ____/____/____
 Date health facility notified county: ____/____/____
 Dates of onset: ____/____/____

For cases of measles, NT, (maternal tetanus), yellow fever, and meningitis:
 Number of vaccine doses received: ____ 9 = unknown
For measles, TT, yellow fever – documented by card, for meningitis, by history.

Date of last vaccination: ____/____/____
(measles, neonatal tetanus, (maternal tetanus), yellow fever, and meningitis only)

Laboratory specimen taken: ____ 1 = Yes 2 = No
If yes, what: ____ 1 = stool 2 = urine 3 = blood 4 = CSF 5 = other _____

In/Outpatient: ____ 1 = inpatient 2 = outpatient

Outcome: ____ 1 = alive 2 = dead 9 = unknown

Final classification: ____ 1 = confirmed 2 = probable/compatible 3 = discarded 4 = suspected

Name of person completing: _____
 Date form sent to MOH/WHO: ____/____/____