White form – RDT Drug Shops

DRUG SHOP VENDOR REGISTER - TREATMENT RECORDING FORM

Record no:		**Date of consultation:** …….../……../…….		
Drug Shop ID:		**Drug Shop Vendor ID:**		**Name of Drug Shop Vendor:**
Client's Subcounty (LCIII):		**Client's Parish (LCII):**		**Client's Village (LCI):**
Client's ID:		**Name of Client:**	**Sex (m/f):**	**Age:**

Client's head of household:

Does the client come from the same village as the Drug Shop?	Yes	
	No	
Did client sleep under a mosquito net last night?	Yes	
	No	

Has the client visited the Drug shop before, for the same illness? Yes / No

If Yes, **Date of visit:__ __/__ __/__ __ __ __**

Record of treatment:

When did the fever start?	Today (same day)		**Body temperature (^{O}C):**		
	Last night				
	Yesterday (day before)				
	More than 2 days ago				
Quick malaria test done?	Yes		**Blood slide taken?**	Yes	
	No			No	
	Refused			Refused	
RDT result?	Yes		**Is the client pregnant?**	Yes	
	No			No	
	Refused			Not applicable	
Treatment given?	Co-Artem Yellow			Co-Artem Blue	
	Co-Artem Orange			Co-Artem Green	
	Artesunate suppository			No treatment given	

Referred?	Yes		*If yes,* **Reason for referral?**	Danger Signs	
	No			Other Signs for Referral	
Did the client get treatment elsewhere?				Yes	
				No	

If yes, **Where did they get treatment and what treatment was given?**

Additional Comments: