COMMUNITY MEDICINE DISTRIBUTOR'S REGISTER

TREATMENT RECORDING FORM

Record no:		**Month:**	**Year:**	
Subcounty (LCIII):		**Parish (LCII):**	**Village (LCI):**	
CMD ID:		**Name of CMD:**	**Date of consultation:**	
Patient ID:		**Name of child:**	**Sex:**	**Age:**
Child's Village of Residence:		**Child's head of household:**		
Does child come from the same village as CMD?			Yes – resident No – non-resident	
Did child sleep under a mosquito net last night? (*circle*)			Yes / No	
Record of treatment:				
When did the fever start?	Today (same day) Yesterday (day before) 2 days ago More than 2 days ago		**Body temperature:**	
Quick Malaria Test done?	Yes No Refused		**Blood slide taken?**	Yes No Refused
RDT result?	Positive Negative			
Treatment given:	Co-Artem Yellow Co-Artem Blue Malaria Suppository No treatment given			
Referred?	Yes No	*If yes,* **Reason for referral:**	Danger Signs Other Signs for Referral	
Additional Comments:				