# Outpatient Care Treatment Card

Adapted from Valid International. 2006. *Community-based Therapeutic Care (CTC): A Field Manual*. Oxford, UK: Valid International.

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| **Name** | | |  | | | | | | | | | | | | | | | | | | | | **Reg. No** | | | | | | | | | | | | **/ /** | | | | | | | |
| **Age (months)** | | |  | | | | | | **Sex** | | | | M F | | |  | | | | | | | **Date of admission** | | | | | | | | | | | |  | | | | | | | |
| **Community, Locality** | | |  | | | | | | | | | | | | | | | | | | | | **Time to travel to site** | | | | | | | | | | | |  | | | | | | | |
| **House location** | | |  | | | | | | | | | | | | | | | | | | | | **Father alive** | | | | | | Yes No | | | | | | **Mother alive** | | | | Yes No | | | |
| **Name of carer** | | |  | | | | | | | | | | | | | **Total number in household** | | | | | | | | | | | | |  | | | | | | **Twin** | | | | Yes No | | | |
| **Admission** | | | Direct from community | | | | | | Referred from  heath facility | | | | | | | Referred from  inpatient care | | | | | | | | | | | | | **Readmission (relapse)** | | | | | | | | | | Yes No | | | |
| **ADMISSION ANTHROPOMETRY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MUAC (mm)** | | |  | | | **Weight (kg)** | | | | | | |  | | | **Height (cm)** | | | | | | |  | | | | **WFH z-score** | | | | | | | |  | | | | | | | |
| **Admission criteria** | | | Bilateral pitting oedema | | | MUAC  < 115 mm | | | | | | | WFH < - 3  z-score | | | Other, specify | | | | | | | | | | | **Target weight (kg) based on 15% weight gain (oedema free)** | | | | | | | | | | | |  | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diarrhoea** | | | Yes | | | No | | | | | | **# Stools/day** 1-3 4-5 >5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vomiting** | | | Yes | | | No | | | | | |  | | | | |  | | | |  | | | | | | **Passing urine** | | | | | | | | | Yes | | | No | | | |
| **Cough** | | | Yes | | | No | | | | | |  | | | | |  | | | | **If oedema, since how long?** | | | | | | | | | | | | | | |  | | | | | | |
| **Appetite** | | | Good | | | Poor | | | | | | None | | | | |  | | | |  | | | | **Breastfeeding** | | | | | | | | | | | Yes | | | No | | | |
| **Additional information** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHYSICAL EXAMINATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Appetite Test** | | | Passed | | | | Failed | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **Respiratory rate**  ***(# per min)*** | | | <30 | | | | 30 – 39 | | | | | 40 - 49 | | | | | 50-59 | | 60 + | | | | | | **Chest Indrawing** | | | | | | | | | | | Yes | | | No | | | |
| **Temperature** | | | 0C | | | |  | | | | |  | | | | |  | |  | | | | | | **Palmar Palor** | | | | | | | | | | | Normal | | | Pale | | | |
| **Eyes** | | | Normal | | | | Sunken | | | | | Discharge | | | | | Conjunctive/  cornea | | **Dehydration based on history** | | | | | | | | | | | | | | None | | | Moderate | | | Severe | | | |
| **Ears** | | | Normal | | | | Discharge | | | | |  | | | | |  | | **Mouth** | | | | | | | | | | | | | | Normal | | | Sores | | | Candida | | | |
| **Enlarged**  **lymph nodes** | | | None | | | | Neck | | | | | Axilla | | | | | Groin | | **Hands & feet** | | | | | | | | | | | | | | | | | Normal | | | Cold | | | |
| **Skin changes** | | | None | | | | Scabies | | | | | Peeling | | | | | Ulcers / Abscesses | | | | | | | | | | | | | | **Disability** | | | | | Yes | | | No | | | |
| **Additional information** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ROUTINE MEDICINES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADMISSION: Amoxicillin** | | | Dosage: | | | | | | | Date: | | | | | | |  | | | | | **Malaria test** | | | | | | Positive Negative | | | | | | | | Date: | | | | | | |
|  | | |  | | | | | | |  | | | | | | |  | | | | | **Malaria Symptoms** | | | | | | Yes No | | | | | | | | | | | | | | |
| **2nd VISIT:Antihelminthic** | | | Yes | | | | | | | No | | | | | | |  | | | | | **Malaria treatment** | | | | | | Drug/Dosage: | | | | | | | | Date: | | | | | | |
| **Week Four: Measles Immunization**  **Vitamin A Suppl** | | | Yes  Yes | | | | | | | No  No | | | | | | |  | | | | | **Fully immunised** | | | | | | Yes No | | | | | | | |  | | | | |  | |
| **OTHER MEDICINES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Drug*** | | ***Date*** | | | | | ***Dosage*** | | | | | | | | | | ***Drug*** | | | | | | | | | | | | | | ***Date*** | | | | | ***Dosage*** | | | | | | |
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| **MONITORING INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Weeks in treatment** | | **ADM.** | | | **1** | **2** | | | **3** | | | **4** | | | **5** | **6** | | | **7** | | **8** | | | | **9** | | **10** | | | | **11** | | **12** | | **13** | | | **14** | **15** | | **16** | |
| Date | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| **ANTHROPOMETRY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 15% Target Weight | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Bilateral Pitting Oedema  **(+ ++ +++)** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| MUAC  **(mm)** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Weight  **(kg)** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Weight loss \*  ***(Y/N)*** | |  | | |  |  | | | **\*** | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| If no weight gain or losing weight, do a home visit; If below admission weight after 3 weeks\* or weight loss for 2 weeks, or static weight for 3 weeks, refer to inpatient care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diarrhoea ***(# days)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Vomiting  ***(# days)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Fever ***(# days)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Cough ***(# days)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| **PHYSICAL EXAMINATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Temperature  (0C) | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Respiratory rate***(# /min)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Dehydrated  ***(Y/N)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Anaemia / palmer pallor  ***(Y/N)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Skin lesion  ***(Y/N)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| **APPETITE CHECK / FEEDING** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RUTF test  ***Passed/Failed*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| RUTF  ***(# units given)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| **ACTION / FOLLOW UP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTION NEEDED ***(Y/N) (note below)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Other medication ***(see front)*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| Name examiner | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| **OUTCOME\*\*** | |  | | |  |  | | |  | | |  | | |  |  | | |  | |  | | | |  | |  | | | |  | |  | |  | | |  |  | |  | |
| \*\* OK=**Continue Treatment** A=**Absent** D=**Defaulted (3 consecutive absences)** R=**Referral** RR**=Refused Referral** C=**Cured** X**=Died** NR**=Non-Recovered** HV**= Home Visit** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ACTION TAKEN DURING HOME VISIT *(INCLUDE DATE)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Community Outreach Worker:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |