Data collection form:

ID Number: 01-01-01-000- _ _ _ _  Verbal assent obtained no / yes
Date: _ _ / _ _ /20 _ _  Time of arrival _ _ : _ _  DD/MM/ YYYY HH:MM

1. What is the gender of the patient?  male / female
2. How old are you (the patient)?  ___ ___ (in months or in years)
3. How did you (the patient) travel to the hospital today?
   walked (or non-vehicle)  police
   bicycled  public vehicle
   personal vehicle  animal
   Motorcycle taxi  other: __________________________

4. Did you (the patient) pay for transport to hospital?  no / yes
5. Did your reason (the patients) for coming to the hospital begin today?  no / yes
   5a. If yes, what time did the event occur/health problem start?  Time _ _ : _ _
      HH:MM
   5b. Where were you (the patient) when the event occurred/ health problem start?
      residence/private home  market
      work  school
      road/street  other: __________________________

6. What city/town did you travel from to come to the hospital?  __________________

7. Why are you (the patient) seeking care today?

   Trauma Penetrating:  Trauma Blunt:
   extremity (≥1)  extremity (≥1)
   chest/abdomen/pelvis  chest/abdomen/pelvis
   head/neck  head/neck
   oromaxillofacial  oromaxillofacial

   Medical:
   chest pain  rash
   shortness of breath/cough  vaginal bleeding
   abdominal pain/vomiting/diarrhea  pregnancy/delivery
   fever  mental health/psychiatric
   oromaxillofacial  other: __________________________

8. Did you (the patient) receive care today prior to coming to the hospital?  no / yes
   8a. If yes, what was done. __________________________________________

Mortality information (to be filled by the data collector, not to be asked to the patient):

9. Did the patient die prior to arrival to the hospital?  no / yes
10. Did the patient die within one hour after arriving at the hospital?  no / yes
   10a. If yes (to 8 or 9) likely cause. _____________________________________