Nodding Syndrome Alliance (NSA)

FAMILY FOLDER

(adapted from Form RSS-MOH-603A)

&

HOUSEHOLD VISIT FORMS

STATE: _____ COUNTY: _____ PAYAM: _____

BOMA: _____ VILLAGE(S): _____

BHW / HHP / CHV Name & Surname: _____ Contact: _____

INSTRUCTIONS for filling up the FAMILY FOLDER

DESCRIPTION AND INSTRUCTIONS FOR USERS

Objective of the register: The family folder will be used at community level to obtain key information on each household to guide the delivery of identification and referral services by Boma Health Workers (BHW), Household Health Promoters (HHP) and Community Health Volunteers (CHV) within the framework of the "*Nodding Syndrome Alliance*" project. As part of this process, the BHW / HHP / CHV will collect and register information on each household in the Boma which includes a person (child or adult) who is suspected to suffer from epilepsy.

This will be family-centred health information that will be collected at the start of the project and updated regularly. This information will be stored with the BHW / HHP / CHV in a folder, hence the name family folder. A family for which a folder should be created will be based on presence of a woman (mostly married) in the family. E.g. in a polygamous family of three women (wives), each woman should be treated as a family with a folder. The man should be recorded under anyone of the families as the head there.

User: BHW, HHP, CHV.

Copies: One copy per household/family and will be kept by each BHW / HHP / CHV under whose care the household falls. Under the project delivery structure, each BHW / HHP / CHV will maintain family folders for all households within the assigned Boma(s) having at least one person with suspected epilepsy.

PROCEDURE

SECTION A.1

1. Record the household number at the top on the right-hand side of the register. The household number takes the form: first three letters in the name of the state (capitals)/first three letters in the name of the county (capitals)/first three letters in the name of the payam(capitals)/first three letters in the name of the boma(capitals)/first three letters in the name of the village/three-digit number in serialized form for households provided by the BHW assigned to this household. For example; if the household numbered 008 lies in Pagak village, Pagak boma, Nyongkuach payam, Baliet county and Upper Nile state, the household number will be written as UPP/BAL/NYO/PAG/PAG/008.
2. Record date of registration of the household.
3. Record other identification information, i.e. name of the state, county, payam, boma and village in the spaces provided in every page of the folder.
4. Record names of the Boma chief, the BHW / HHP / CHV and supervisor.

5. Because newer members likely to be added onto the household may be younger children, it may be good to record members of the household from the oldest to the youngest. All members born in the household should be recorded, including those who have died. Only list members of the household who have been staying there, excluding visitors (only those who have been in the household for at least 6 months except those newly born members of the household).
6. Do not fill anything in any shaded field.
7. If a member registered in the household/family leaves the household permanently, ensure you single-strike through the name of the person permanently leaving and explain under the remarks column. For example, a member of the household/family who decides to marry hence establishing his/her own family will have to be struck off only by the name then explained in the remarks column that this person has his own family established.

Section	Data element	Information to record
SECTION A.2	**Name**	Record name of household member. **Note**: In polygamous families, ensure the man is registered in only one of the households. The other(s) should be registered with either of the wives as head of household.
	Age	Record age of household member in completed months or years. Age of children below 5 years should be recorded in months. For persons 5 years and above, record the age in completed years.
	Sex (M/F)	Record **M** for male or **F** for female.
	Date of birth dd/mm/yy	Record date in the order day/month/year, each carrying two characters e.g. 04/11/18. For household members with national identity card (Jensia), it is advisable to confirm date of birth from the Jensia.
	Status **1-Alive, 2-Dead**	Record 1 if the household member is alive or 2 if the household member has died. Always carefully probe to find if someone is dead or alive. E.g. if you are recording about Soro Felix Luka, you can ask; where is Soro Felix Luka now? Automatically you will be told that he has gone somewhere, is at home or died.
	Date of death dd/mm/yy	Record date of death in the order day/month/year, each carrying two characters e.g. 04/11/18.
	Disability? (Y/N)	Record '**YES**' if the person has any form of disability, record '**NO**' if there is no disability
	Relation in HH *1-Head of household 2-Spouse 3- Son 4-Daughter 5-Others(specify)*	Record the code that states how the household member is related to the household head. Record **1** for household head, **2** for spouse (wife or husband), **3** if son to household head**, 4** if daughter to household head and **5** for any relationship which should be specified other than 1-4.
	Remarks	Write any relevant comment not captured in the data elements above. E.g. explaining what other relationship actually is. If a household member leaves the household permanently, e.g. gets married later, it is important to single-strike the name and update in the "Remarks" column.

Section	Data element	Information to record
SECTION A.3	**Name**	Record name of household member as in Section A.2
	Age	Record age of household member as in Section A.2
	Sex (M/F)	Record **M** for male or **F** for female, as in Section A.2
	Unusually sleepy or unconscious? (Y / N)	Record '**YES**' if the child or adult is usually sleepy or unconscious or '**NO**' if the child is not usually sleepy or unconscious. This applies to children and adults alike. Note: A child who is usually sleepy can sometimes be awake but does not follow anything the BHW / HHP / CHV does to attract his/her attention (e.g. moving a pen up and down in front of him/her).
	Convulsions? (Y / N)	Record '**YES**' if the person is having or the head of household reports convulsion(s) the person has had in the current or in previous episodes of illness. If no convulsions, record '**NO**'. This applies to children and adults alike.
	Fever? Y/N	Record' **YES**' if the person had convulsions with high fever, record '**NO**' for the person who had convulsions without fever in the last episode of illness. This applies mainly to children aged 0-59months.
	More than 1 seizure / fit over the last year? (Y / N)	Record '**YES**' if the person (or the head of household reports the person) has had more than 1 seizure/fit **over the last 12 months** (i.e. one year) **and at least 48 hours apart**. If no more than 1 seizure/fit over the last 12 months (and at least 48 hours apart), record '**NO**'. This applies to children and adults alike.
	Head Nodding? (Y / N)	Head nodding is defined as repetitive, involuntary drops of the head to the chest on two or more occasions. Record '**YES**' if the person head nods or the head of household reports the person head nodding. If no head nodding, record '**NO**'. This applies to children and adults alike.
	Referred to Health Facility (HF)? (Y / N)	Any person: - who has had (or has been reported of having had) more the 1 seizure/fit over the last 12 months **OR** has Head Nodding - **AND** is not currently under epilepsy treatment at a licensed health facility, **must be referred** to the epilepsy clinic of a health facility for further investigation. If the person has been referred by the BHW / HHP / CHV to a health facility, record '**YES**'; if the person has not been referred to a health facility, record '**NO**'.
	Name of HF referred to & REFERRAL FORM Numb. ***OR*** **Reason for not referring to HF.**	If the response to the previous question is '**YES**', here the BHW / HHP / CHV records: - The name of the Health Facility (HF) to which the referral was made, **AND** - The REFERRAL FORM Number. If the response to the previous question is '**NO**', here the BHW / HHP / CHV records the reason for not referring the person to the Health Facility.

DESCRIPTION AND INSTRUCTIONS for filling up the HOUSEHOLD VISIT FORMS

This form is for recording **data of patients diagnosed with epilepsy only**, collected during household visits by the BHW / HHP / CHV.

Sections	Data element	Information to record
SECTION 2.B	**Serial Number (S / N)**	Insert the Serial Number of the **members with** (either suspected or already confirmed) **Epilepsy / Nodding Syndrome**. Insert the SN as indicated in the **FAMILY FOLDER – Section A3** produced for this specific household (e.g. 01, 02, …, 14). **Note:** a "Suspected case of Epilepsy" is a person who had at least 2 unprovoked seizures 48 hours apart and in the last 12 months"; a "Suspected case of Nodding Syndrome" is a previously normal person who reports head nodding.
	Name of the household member with suspected epilepsy	Insert name of the household member with (either suspected or already confirmed) **Epilepsy / Nodding Syndrome**, as indicated in the FAMILY FOLDER produced for this specific household.
	Age	Record age of household member in completed months or years. Age of children below 5 years should be recorded in months. For persons 5 years and above, record the age in completed years.
	Sex (M/F)	Record '**M'** for male or '**F**' for female.
	Diagnosis	If the patient was diagnosed at a Health Facility with **Epilepsy**, insert '**1**'. If the patient was diagnosed at a Health Facility with **Nodding Syndrome**, insert '**2**'. If the patient was diagnosed at a Health Facility with **Onchocerciasis** ("OV", "River Blindness"), insert '**3**'. If the patient was diagnosed at a Health Facility with **Malaria**, insert '**4**'. If the patient was diagnosed at a Health Facility with **other conditions**, insert '**5**' and specify the diagnosis. If the patient has not gone and/or has not obtained a diagnosis at a Health Facility yet**, leave blank & refer for diagnosis**.
	Diagnosis from which Health Facility?	If the patient has obtained a diagnosis from a Health Facility, insert the **name and level of the Health Facility**. The level of Health Facility can be either: PHCU; PHCC; Hospital.
	Date of diagnosis	Record date of diagnosis in the order day/month/year, each carrying two characters e.g. 04/11/18.
	Under care of SEM Community-Based Rehabilitation Worker?	If the patient is not under care of a CBRWorker from SEM, tick "**NO**". If the patient is under care of a Community-Based Rehabilitation Workers from Sudan Evangelical Mission (SEM), tick "**YES**" and record the **name of the CBRWorker.** You can do so by checking the SEM Client Card held by the patient.
SECTION 2.C	*Do not plan household visits (recorded under Section 2C) for:* *i. Patients **without** Epilepsy or Nodding Syndrome;* *ii. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.*	

Sections	Data element	Information to record
SECTION 2.C	**Visit date**	Record date of household visit in the order day/month/year, each carrying two characters e.g. 04/11/18.
	S/N & Pt's Name initials	Insert the Serial Number (S/N) of the patient with Epilepsy / Nodding Syndrome, as indicated in **SECTION 2B** filled for this specific household (01, 02, 03, …, 14), plus the Patient's Name initials.
	Number of seizures in the last 7 days?	Insert the number of seizures / fits that the patient has had in the last 7 days. This number can be reported by the patient himself, or by the closest adult relative. Write the number of times the person has had seizures: 1,2,3, etc.
	AEDs received since last HH visit? (Y / N) **If yes, from where?**	If the patient has obtained Anti-Epileptic Drugs since the last household visit, record '**YES**'; if the patient has not received any new quantity of AEDs, record '**NO**'. If YES is recorded, please specify the source of the AEDs – for instance: a **local pharmacy**, a **charity organization** (insert name), a **health facility** (insert name and level of the HF)
	Type of AEDs	If the patient is taking AEDs, record the name of the Anti-Epileptic Drug: **phenobarbital, phenytoin, carbamazepine, valproic acid**, etc.
	AEDs remaining (no. of pills)	If the patient has AEDs, count the Pills that are remaining and insert the **number of pills**. If the patient does not have any AEDs remaining, record '**0**' (zero).
	Adverse Effects? (Y / N) **If "YES", record effects**	If the patient taking AEDs did not experience adverse effects, tick '**NO**'. If the patient taking AEDs experienced adverse effects, tick 'YES' and **list the adverse effects**.
	No. of visits to HFs since last HH visit? Which HF?	If the patient visited a Health Facility since the last household visit, record the **number of visits and the name(s) & level of the health facility(ies)**. If the patient did not visit a Health Facility since the last household visit, record '**0**' (zero).
	Referred to HF? (Y / N) **If yes, insert Referral Form No.**	If the BHW / HHP / CHV does not refer the patient to a health facility, record '**NO**'. If the BHW / HHP / CHV refers the patient to a health facility, record '**YES**' **and insert the Referral Form Number**.

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
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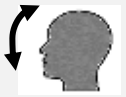
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
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07										
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14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

i. Patients **without** Epil epsy or Nodding Syndrome;

ii. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
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			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
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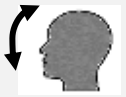
SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

iii. Patients **without** Epil epsy or Nodding Syndrome;

iv. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED 	AED pills remaining 	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF? 	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED 	AED pills remaining 	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF? 	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: ___ ___ ___ ___ ___

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
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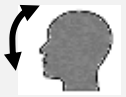
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	Name of BHW / HHP / CHV:	Name of supervisor:	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

v. Patients **without** Epil epsy or Nodding Syndrome;

vi. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

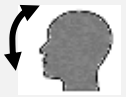
SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
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05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

vii. Patients **without** Epil epsy or Nodding Syndrome;

viii. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: ___ ___ ___ ___ ___

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

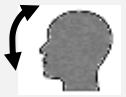
SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

ix. Patients **without** Epil epsy or Nodding Syndrome;

x. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED 	AED pills remaining 	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF? 	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

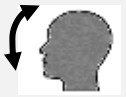
SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

xi. Patients **without** Epil epsy or Nodding Syndrome;

xii. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

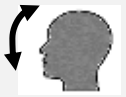
SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	Name of BHW / HHP / CHV:	Name of supervisor:	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

xiii. Patients **without** Epil epsy or Nodding Syndrome;

xiv. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: ___ ___ ___ ___ ___

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

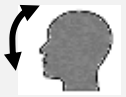
SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

xv. Patients **without** Epil epsy or Nodding Syndrome;

xvi. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED 	AED pills remaining 	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF? 	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED 	AED pills remaining 	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF? 	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

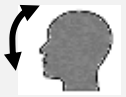
SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS ***OR*** previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

xvii. Patients **without** Epil epsy or Nodding Syndrome;

xviii. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FAMILY FOLDER

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

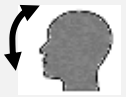
SECTION A.1: HOUSEHOLD IDENTIFICATION DETAILS

Date/Year of first Registration (DD/MM/YY): _____/_____/_____			
State:	County:	Payam:	
Boma:	Village:	Chief's Name:	Tel:
Name of BHW / HHP / CHV:		Name of supervisor:	Tel:

SECTION A.2: LIST OF FAMILY/HOUSEHOLD MEMBERS

S/N	Name	Age	Sex (M/F)	Date of Birth (dd/mm/yy)	Status: 1-Alive, 2-Dead	Date of death (dd/mm/yy)	Disability: (Yes / No)	Relation in HH *1-Head of household, 2-Spouse, 3- Son, 4-Daughter, 5-Others(specify)*	Remarks
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

SECTION A.3: IDENTIFYING FAMILY MEMBERS WITH SUSPECTED EPILEPSY / NODDING SYNDROME

S/N	Name	Age	Sex (M / F)	 Unusually sleepy or unconscious? (Y / N)	 Convulsions? (Y / N)	 Fever? (Y/N)	 More than 1 seizure / fit over the last year? (Y / N)	 Head Nodding? (Y / N)	 Referred to Health Facility (HF)? (Y / N)	Name of HF referred to & REFERRAL FORM Number. ***OR*** Reason for not referring to HF.
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										

Section 2.A

State:	County:	Payam:	Boma:
Village Chief's Name:	**Name of BHW / HHP / CHV:**	**Name of supervisor:**	

Section 2.B - DIAGNOSES

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S/N (as in A3)	Name of the household member with suspected epilepsy / NS *OR* previously confirmed epilepsy /NS	Age	Sex (M/F)	Diagnosis '**1**' = Epilepsy, '**2**' = Nodding Syndrome, '**3**' = Oncho, '**4**' = Malaria, '**5**' = Others (specify)	Diagnosis from which Health Facility?	Date of diagnosis (dd/mm/yy)	Under care of SEM Community-Based Rehabilitation Worker?
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:
							□ No □ Yes, name:

Do not plan household visits (recorded under Section 2C) for:

xix. Patients **without** Epil epsy or Nodding Syndrome;

xx. Patients already **under the care of SEM** Community-Based Rehabilitation Workers.

Section 2.C – HOUSEHOLD VISITS

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED 	AED pills remaining 	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF? 	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:
			□ No □ Yes, from:			□ No □ Yes, effects:		□ No □ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 2.C – HOUSEHOLD VISITS [Continued]

Visit Date	S/N & Pt's Name initials	Number of seizures in the last 7 days?	AEDs given since last HH visit? (Y / N) If yes, from where?	Type of AED	AED pills remaining	Adverse Effects of AED? (Y / N) If "YES", record effects	No. of visits to HFs since last HH visit? Which HF?	Referred to HF? (Y / N) If "YES", insert Referral Form No.
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:
			☐ No ☐ Yes, from:			☐ No ☐ Yes, effects:		☐ No ☐ Yes, insert RF No.:

HOUSEHOLD NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _