Data collection form:
ID Number: 01-01-01-000- _ _ _ _ Verbal assent obtained no □ / yes □

Date: _ _ /_ _ /20 _ _ Time of arrival _ _:_ _
DD/MM/ YYYY HH:MM

1. What is the gender of the patient? male □ / female □

2. How old are you (*the patient*)? __ __ (in months □ or in years □)

3. How did you (*the patient*) travel to the hospital today?

walked (or non-vehicle)	□	police	□
bicycled	□	public vehicle	□
personal vehicle	□	animal	□
Motorcycle taxi	□	other: _____	□

4. Did you (*the patient*) pay for transport to hospital? no □ / yes □

5. Did your reason (*the patients*) for coming to the hospital begin today? no □ / yes □

5a. If yes, what time did the event occur/health problem start? Time _ _:_ _
HH:MM

5b. Where were you (*the patient*) when the event occurred/ health problem start?

residence/private home	□	market	□
work	□	school	□
road/street	□	other: _____	□

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

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

Trauma Penetrating:		**Trauma Blunt:**	
extremity (≥1)	□	extremity (≥1)	□
chest/abdomen/pelvis	□	chest/abdomen/pelvis	□
head/neck	□	head/neck	□
		oromaxillofacial	□
Medical:	□		□
chest pain	□	rash	□
shortness of breath/cough	□	vaginal bleeding	□
abdominal pain/vomiting/diarrhea	□	pregnancy/delivery	□
fever	□	mental health/psychiatric	
oromaxillofacial	□	other:_____	□

8. Did you (*the patient*) receive care **today** prior to coming to the hospital? no □ / yes □

8a. If yes, what was done. _____

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

9. Did the patient die prior to arrival to the hospital? no □ / yes □

10. Did the patient die within one hour after arriving at the hospital? no □ / yes □

10a. If yes (*to 8 or 9*) likely cause. _____