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|  | **Condition Assessment Form**About this form: To gather basic information about the patient upon arrival at the health facility including their health condition. Can be used to compare health conditions of patients arriving at ahealth facility via different modes of transport. |
|  |
| **1** | Unique Identification Number: |   |
| **2** | Date: |   |
| **3** | Health Centre name: |   |
| **4** | Name and signature of Health Worker |   |
| **5** | Patient’s name (sick person/child) |   |
| **6** | Patient’s address |   |
| **7** | Time of call made for emergency transport | **: AM/PM** |  |
| **8** | Time of departure from start location/home | **: AM/PM** |  |
| **9** | Time of arrival at health facility/hospital | **: AM/PM** |  |
| **10** | **(Complete only in case of referral)**Time of Referral requested | **: AM/PM** |  |
| **11** | **(Complete only in case of referral)**Time of Departure | **: AM/PM** |  |
| **12** | Vital Signs Assessment | *Complete on table below* |
|  |  |  |  |  |  |
|  | TEMP |   |  |  |  |
|  | PULSE |   |  |  |  |
|  | BP systolic (top) |   |  |  |  |
|  | BP diastolic (bottom) |  |  |  |  |
|  | RESPS |   |  |  |  |
|  | URINE |   |  |  |  |
|  | **TOTAL** |  |  |  |  |

