

ANNEX 1: DATA COLLECTION FORM

Patient ID				
Demographic information				
Facility name Location				
Location				
Patient/guardian contact (phone number)				
Type of Health facility	1. Dispensary, 2. Health Centre, 3. District hospital, 4. Regional, 5. Tertiary hospital			
Type of patient	1. Child, 2. Adult non-Pregnant, 3. Pregnant			
Age				
Date of Birth (DD/MM/YYYY)	[][]/[][]/[][][][]			
Gender	1. Female, 2. Male			
Occupation	1. Farmer, 2. Business, 3. Housewife, 4. Civil servant, 5. Still on studies, 6. None, 7. Other [Specify.....]			
Religion	1. Christian 2. Muslim, 3. Other [Specify.....]			
Marital status	1. Single, 2. Married/Cohabiting			
Type of latrine	1. Pit latrine, 2. Squat type flush latrine, 3. Western type flush latrine, 4. NA			
Source of water	1. Tap water, 2. Well water, 3. Borehole water, 4. Lake			
Clinical information				
Date of visit (DD/MM/YYYY)	[][]/[][]/[][][][]			
Symptoms 1a to 1f				
1a. Pregnant woman with the following symptoms and signs(tick)	Lower abdominal pain		Flank/back pain	
	Strong-smelling urine		Fever	
	Dysuria		Pyuria	
	Haematuria		Haematuria	
18b non-Pregnant woman or man with the following symptoms and signs (tick)	Lower abdominal pain		Flank/back pain	
	Strong-smelling urine		Fever	
	Dysuria		Pyuria	
	Haematuria		Haematuria	
18c Child with the following symptoms and signs	Lower abdominal pain		Flank/back pain	
	Strong-smelling urine		Enuresis	
	Fever		Dysuria	
	Pyuria		Haematuria	
	Urgency		Frequency	
	Costovertebral angle tenderness			
	Abdominal or Suprapubic tenderness to palpation			
Palpable bladder; dribbling/poor stream				
Symptoms onset date (DD/MM/YYYY)	[][]/[][]/[][][][]			
Duration of symptoms	Days.....			
Recurrence of symptoms	1. YES, 2. No, 3. NA			
Previous treatment	1. YES, 2. No, 3. NA			
Type of previous treatment	1. Antibiotic, 2. Traditional medicine, 3. Ant-Pain, 4. Others [Specify			
If antibiotic mention			
Was treatment prescribed	1. YES, 2. No, 3. NA			

If yes, who prescribed the treatment	Mention.....		
Where did you obtain treatment	1. Health facility, 2. Community pharmacy, 3. Others [Specify		
Any comorbidity (tick)	HIV		DM
	Hypertension		Cancer
	Congenital anomalies		
	Other [Mention.....]		
Have you ever visited a hospital in the last 30 days?	1. YES, 2. No		
When was your last hospital visit	1. In the last 7 days, 2. In the last 2 weeks, 3. In the last 3 weeks 4. In the last 4 weeks, 5. NA		
Were you admitted?	1. YES, 2. No, 3. NA		
History of antibiotic use in the past 3 months	1. YES, 2. No, 3. NA		
Type of antibiotics used			
What was the diagnosis?			
Who made the diagnosis?	1. Doctor, 2. Pharmacist, 3. Nurse, 4. Lab personnel, 5. Other [mention].....		
How was the diagnosis made?	1. Clinically, 2. Lab test, 3. Other [mention].....		
Sample collected	1. MSU, 2. Catheter urine, 3. Suprapubic urine		
Sample collection time Hrs: Min	[24 hrs format] [] [] Hrs: [] [] Min		
Antibiotic prescribed before culture and AST results			
Urinalysis results	[Leucocytes] , 1. Negative, 2. +1, 3. +2, 4. +3		
	[Glucose] , 1. Negative, 2. +1, 3. +2, 4. +3		
	[Blood] , 1. Negative, 2. +1, 3. +2, 4. +3		
	[Nitrite] , 1. Negative, 2. Trace, 3. Positive		
Urine culture results	1. NBG, 2. NSG, 3. SBG		
ESBL test results	1. Positive, 2. Negative, 3. NA		
Date urine culture results released (DD/MM/YYYY)	[] [] / [] [] / [] [] [] []		
GPS			