Verbal autopsy form for interviewing family of reported AEFI (death of an adult/person >15 years of age)

EPID NO........ / .... / ....

To be filled in all death cases except in those hospitalized cases in which cause of death is certain.

I would like to ask you some questions concerning signs and symptoms that the deceased person had/showed prior to and/or at the time of death, previously known medical conditions the deceased person had and injuries and accidents that the deceased person suffered. Some of these questions may not appear to be directly related to the death. Please bear with me and answer all the questions. They will help us to get a clear picture of all possible conditions that the deceased person had.

Section 1. Basic details:

A) Patient identifiers

Name of the deceased person: Age (years): Sex (Male/Female/Other):

Date of birth: Educational status of deceased:

Occupation of the deceased:

Marital status of deceased:

State: District: Town: Block: Village:

Complete address:

Pin code:

Name of the head of the Household:

B) Details of respondent

Sr No	Details of respondent	Relation with deceased
1		
2		
3		
4		
5		
6		

Main respondent's age: Sex (Male/Female/Other) Education:

Contact number:

Did the respondent live with the deceased during the events that led to death? (Yes/No)

Date and time of death: ____

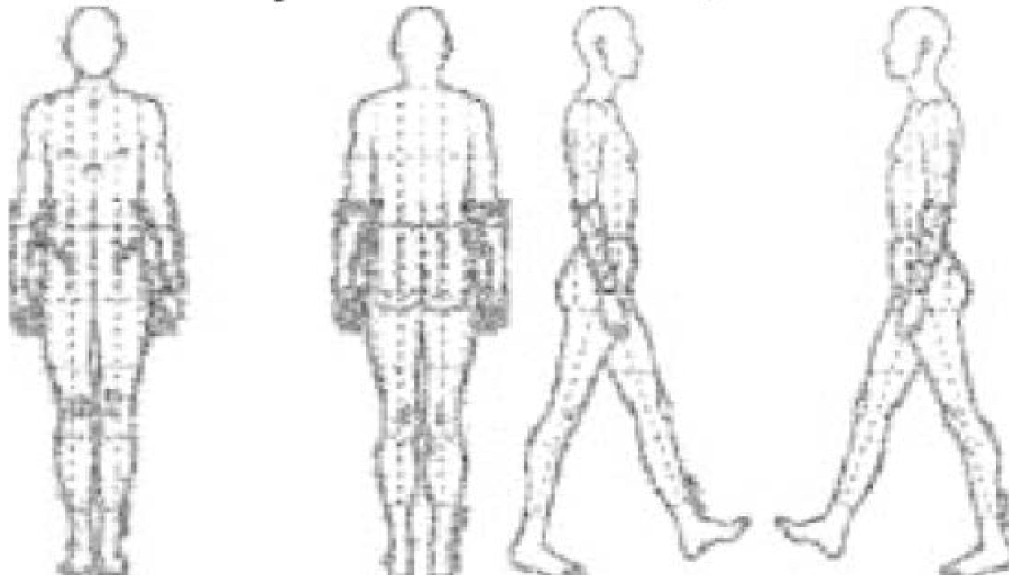
Place of death: Home/govt facility/private facility/others specify___________

C) Details of current COVID-19 vaccination:

Date: Time: Place:

Vaccine Name/Brand name	Route (IM/ID/SC)	Site (Verify site from the respondent)

Fig.1. Drawing of front, back, left side and right side of adult to mark injection sites with respective vaccines, location of swelling at or near injection site and position at time of death. (Source: Brighton collaborations definitions)



Who administered the vaccine(s): ANM/LHV/PHN/Pharmacist/Doctor/Others specify __________

D) Past history of the deceased person:

- Previous immunization received: Collect immunization card if available and check the details.
- Reactions to previous vaccines: Yes/No (If yes, specify _______________)
- Pre-existing illness: Yes/No (If yes, specify ____)
- History of Hospitalization in the last 30 days with cause____: Yes/No (If yes, specify _______________)

- History of any medication: Yes/No (If yes, specify ____)
- Weight of the deceased person(in kgs) :

Section 2: Respondent's Account of Illness/Events Leading to Death

- Could you tell me the events that led to his/her death?
  ____
  ____
  ____
  ____
  ____

- Cause(s)/ circumstances of death according to the respondent?
  ____

Section 3: History of previously known Medical Conditions:

Please tell me if the deceased suffered from any of the following illnesses in the past:

- High Blood Pressure: Yes/No/Don't Know
- Diabetes: Yes/No/Don't Know
- Asthma: Yes/No/Don't Know
- Chronic Lung disease: Yes/No/Don't Know
- Stroke: Yes/No/Don't Know
- Cancer: Yes/No/Don't Know (If Yes, specify ______________________)
- Coronary artery disease: Yes/No/Don't Know
- Epilepsy/Convulsions: Yes/No/Don't Know
- Allergy/Atopy (to specify) : Yes/No/Don't Know
- Suicidal thoughts/Any other psychiatric illness: Yes/No/ Don't know (If Yes, specify_________)
- Tuberculosis: Yes/No/Don't Know
- COVID-19 : Yes/No/Don't Know
- HIV/AIDS: Yes/No/Don't Know
- Malnutrition: Yes/No/Don't Know
- History of early sudden death in family member's especially first degree relatives: Yes/No/Don't Know
- Any other medically diagnosed illness: Yes/No/Don't Know (If Yes, specify_______________)

Section 4: History of Injuries/Accidents:

1. Did s/he suffer from any injury or accident that led to his/her death? Yes/No/Don’t know
2. If yes, what kind of injury or accident did the deceased suffer? (encircle one)
3. Road traffic accident/Fall/Drowning/Poisoning/Burns/Violence or Assault/Other (Specify_________________)/don’t know
4. Was the injury or accident intentionally inflicted by someone else? Yes/No/Don’t know
5. Do you think s/he has committed suicide? Yes/No/Don’t know
6. Did s/he suffer from any animal/snake/scorpion or insect bite that led to his/her death? Yes/No/Don’t know (If yes, specify_________________________)
7. Did s/he suffer from lightning strike? Yes/No/don’t know

If the patient is a woman fill in the response to Section 5

Section 5:

1. Did she have an ulcer or swelling in the breast? Yes/No/don’t know (If yes for how long______)
2. Did she have excessive vaginal bleeding during menstrual periods? Yes/No/don’t know (If yes for how long specify___________________)
3. Did she have menstrual bleeding in between menstrual periods? Yes/No/don’t know (If yes for how long specify __________________________)
4. Did she have abnormal vaginal discharge? Yes/No/don’t know (If yes for how long specify___________)
5. Did she have vaginal bleeding after cessation of menstruation? Yes/No/don’t know (If yes for how long specify____________)
6. Did she have an operation to remove her uterus shortly before death? Yes/No/Don’t know

If the patient is a woman is pregnant, fill in the response to Section 6

Section 6: (If response to Q19 is No/Don’t know, skip to Q26)

1. Was she pregnant at the time of death? Yes/No/don’t know
   If yes for how long was she pregnant? (Weeks/Months/don’t know)
2. How many pregnancies had she had including this one? ___________
3. During the last 3 months of pregnancy did she suffer from any of the following illnesses?
   a. Vaginal bleeding? Yes/No/don’t know
   b. Foul smelling vaginal discharge? Yes/No/don’t know
   c. Puffiness of face? Yes/No/don’t know
   d. Headache? Yes/No/don’t know
   e. Blurred vision? Yes/No/don’t know
   f. Convulsion? Yes/No/don’t know
   g. Febrile illness? Yes/No/don’t know
   h. Severe abdominal pain that was not labor pain? Yes/No/don’t know

i. Pallor and shortness of breath? Yes/No/don't know

4. Did she suffer from any other illness __________________________? Yes/No/don't know
5. Did she die during labor, but undelivered? Yes/No/don't know
6. Did she give birth recently? Yes/No/don't know
7. How many days after giving birth of her child did she die? ________________in days
8. Was there excessive bleeding on the day labor started? Yes/No/don't know
9. Was there excessive bleeding during labor before delivering the baby? Yes/No/don't know
10. Was there excessive bleeding after delivering the baby? Yes/No/don't know
11. Did she have difficulty in delivering the placenta? Yes/No/don't know
12. Was she in labor for unusually long (more than 24 hours)? Yes/No/don't know
13. Was it a normal vaginal delivery? Yes/No/don't know
    If No, what type of delivery was it? Forceps/Vacuum/LSCS/other please specify_________
14. Did she have foul smelling vaginal discharge? Yes/No/don't know
15. Where did she give birth? Home/Hospital/Other health facility ___________________
16. Who conducted the delivery? Doctor/Nurse or Mid Wife/ Traditional birth attendant/relative/Mother by herself/other/don't know
17. What was the birth weight of the baby? _________ kg/grams
    If birth weight is not known, what was size of the baby (ask to show photo if available)? Average/bigger than average/ smaller than average/do not know
18. Was the baby's body soft, pulpy and discolored and the skin peeling away? Yes/No/don't know
19. Did she experience an abortion recently? Yes/No/don't know
20. Did she die during the abortion? Yes/No/don't know
21. How many days before death did she have an abortion? ________________________
22. How many months pregnant was she when she had the abortion? ___________
23. Did she have heavy bleeding during the abortion? Yes/No/don't know
24. Was the abortion spontaneous or induced? Yes/No/don't know
25. Did she take medicine or treatment to induce the abortion? Yes/No/don't know
26. Did she have any altered sensorium? Yes/No/don't know
27. Did she have weakness in any limb? (Mono/hemi/quadriparesis/other)
28. Did she have any history of neck stiffness? Yes/No/don't know
29. Did she have jaundice during pregnancy? Yes/No/don't know
30. Did she have any history on single limb swelling? Yes/No/don't know

Section 7: Symptoms and signs noted during the final illness with respect to systems:

General questions:

1. For how long was s/he ill before s/he died? _____________

2. Did s/he have fever? Yes/No/don't know (If yes for how long specify___________)
3. Was the fever continuous or intermittent? (Continuous/Intermittent/ don't know)
4. Did s/he have fever only at night? Yes/No/don't know
5. Did s/he have chills and rigor? Yes/No/don't know

A. Questions pertaining to RESPIRATORY system: (If response to Q1 is No/Don't know, skip to Q5)

1. Did s/he have a cough? Yes/No/don't know(If yes for how long specify___________)
2. Was the cough severe? Yes/No/don't know
3. Was the cough productive with sputum? Yes/No/don't know
4. Did s/he cough out blood? Yes/No/don't know
5. Did s/he have night sweats? Yes/No/don't know
6. Did s/he have breathlessness? Yes/No/don't know(If yes for how long___________)
7. Was s/he unable to carry out daily activities due to breathlessness? Yes/No/don't know
8. Was s/he breathless while lying flat? Yes/No/don't know
9. Did s/he have wheezing? Yes/No/don't know

B. Questions pertaining to cardiovascular system: (If response to Q1 is No/Don't know, skip to Q10)

1. Did s/he have chest pain? Yes/No/don't know (If yes for how long specify_________)
2. Did chest pain start suddenly or gradually? Yes/No/don't know
3. When s/he had severe chest pain, how long did it last? ___________
4. Was the chest pain located below the sternum? Yes/No/don't know
5. Was the chest pain located over the heart and did it spread to the left arm or left jaw? Yes/No/don't know
6. Was the chest pain located over the ribs? Yes/No/don't know
7. Was the chest pain continuous or on and off? Continuous/On and off/don't know
8. Was the chest pain sudden in onset? Yes/No/don't know
9. Did chest pain get worse while coughing? Yes/No/don't know
10. Did s/he have palpitations? Yes/No/don't know

C. Questions pertaining to gastrointestinal system:

(If response to Q1 is No/Don't know, skip to Q5)

(If response to Q6 is No/Don't know, skip to Q9)

(If response to Q9 is No/Don't know, skip to Q13)

1. Did s/he have diarrhea? Yes/No/don't know (If yes for how long specify_________)
2. Was the diarrhea continuous or on and off? Continuous/On and off/don't know
3. When the diarrhea was most severe, how many times did s/he pass stools in a day? _________
4. Any associated symptoms with diarrhea ___________________

5. At any time during the final illness was their blood in stool? Yes/No/don't know
6. Did s/he have vomiting? Yes/No/don't know(If yes for how long specify_________)
7. When the vomiting was most severe, how many times did s/he vomit in a day? _________
8. What was the colour of the vomitus? Coffee colored/Bright red/Others/Don't know
9. Did s/he have abdominal pain? Yes/No/don't know (If yes for how long_________________)
10. Where exactly was the site of abdominal pain? (Left/Right/Upper/Lower/All over/ don't know)
11. Did the abdominal pain radiate? Yes/No/don't know
12. If so, please specify where exactly did it radiate _______
13. Did s/he develop Jaundice? Yes/No/don't know
14. Did s/he develop black tarry stools? Yes/No/don't know
15. Did s/he have abdominal distension? Yes/No/don't know(If yes for how long specify_____
16. Did the distension develop rapidly within days or gradually over weeks or months? ________
17. Was there a period of a day or longer during which s/he did not pass stool? Yes/No/don't know
18. Did s/he have mass in the abdomen? Yes/No/don't know(If yes for how long specify____)
19. Where in the abdomen was the mass located? Encircle one or many as applicable(Right upper/Left upper/Right lower/Left lower/All over the abdomen/ Don't know)
20. Did s/he have difficulty or pain while swallowing solids? Yes/No/don't know(If yes for how long specify__________
21. Did s/he have difficulty or pain while swallowing liquids? Yes/No/don't know(If yes for how long specify_________________

D. Questions pertaining to central nervous system:

(If response to Q1 is No/Don't know, skip to Q7),

(If response to Q15 is No/Don't know, skip to Q22)

(If response to Q30 is No/Don't know, skip to Q34)

1. Did s/he have headache? Yes/No/don't know (If yes for how long___________)
2. Was the headache severe? Yes/No/don't know
3. Please describe the pattern, progression and distribution of headache________________________
4. Did s/he have any accompanying symptoms with headache? Yes/No/don't know
5. If yes please specify the symptom ______________________________
6. Did the headache affect his or her social activities? Yes/No/don't know
7. Did s/he have painful or stiff neck? Yes/No/don't know(If yes for how long specify______)
8. Did s/he have mental confusion? Yes/No/don't know(If yes for how long specify_________)
9. Did the mental confusion start suddenly, quickly within a single day or slowly over many days? _______
10. Did s/he become unconscious? Yes/No/don't know(If yes for how long specify________)
11. Did the unconsciousness start suddenly, quickly within a single day or slowly over many days? _______

12. Did s/he have convulsions (mirgi/daura)? Yes/No/don’t know(If yes for how long specify______)
13. Was s/he unable to open the mouth? Yes/No/don’t know(If yes for how long specify______)
14. Did s/he have stiffness of the whole body? Yes/No/don’t know(If yes for how long specify______)
15. Did s/he have paralysis of one side of the body? Yes/No/don’t know(If yes, specify which side: left/right and for how long ______)
16. Did the paralysis start suddenly, quickly within a single day or slowly over many days? _______
17. How did the weakness progress? Progressive/Intermittent/Step ladder/Others/Don’t know
18. Did s/he have paralysis of lower limb(s)? Yes/No/don’t know (If yes, for how long specify_______)
19. Was the paralysis involve one or both lower limbs? One limb/ both limbs (If one limb, which side limb specify: left / right / donot know)
20. Did the paralysis of lower limbs start suddenly, quickly within a single day or slowly over many days? _______
21. Did s/he have loss or disturbance in Gait/Balance? Yes/No/don’t know
22. If yes, please specify the pattern or type of Gait ________________________________
23. Did s/he have vertigo? Yes/No/don’t know
24. Did s/he have diplopia? Yes/No/don’t know
25. Did s/he have numbness over the face? Yes/No/don’t know
26. Did s/he have slurring of speech? Yes/No/don’t know
27. Was s/he suffering from diaphoresis (ghabrahat)? Yes/No/don’t know
28. Was s/he suffering from bladder or bowel disturbances? Yes/No/don’t know
29. Was s/he suffering from loss of sensation in any part of body? Yes/No/don’t know(If yes specify the location________________
30. Was s/he suffering from abnormal sensations like paresthesia/tingling sensation etc.? Yes/No/don’t know
31. If so please describe the pattern of abnormal sensation as to how did it begin and progress and finally distribute itself? ____
32. Did the abnormal sensations start suddenly, quickly within a single day or slowly over many days? _______
33. Did s/he have preceding symptoms like headache/vomiting or fever? If yes specify _________
34. Was there any recorded fluctuation of pulse/blood pressure/dizziness/spells of syncope? If yes specify _____________
35. Please give a timeline of the symptoms as to which came first to last and how did it progress? ____
____
____
____

E. Questions pertaining to genitourinary system:

1. Did s/he have burning micturition? Yes/No/don't know
2. Was there any change in the colour of urine? Yes/No/don't know (If yes for how long______)
3. Did s/he pass blood in urine? Yes/No/don't know (If yes for how long______________)
4. Was there any change in the amount of urine passed daily? Yes/No/don't know (If yes for how long _____________________
5. Did s/he pass too much urine, too little urine or no urine at all?
6. Too much urine/Too little urine/No urine at all/don't know
7. Did s/he wakes up frequently at night to relieve urine? Yes/No/don't know
8. If yes how many times at night does s/he wake up to urinate? ____________
9. Did s/he have flank pain with fever? Yes/No/don't know
10. Did s/he have suprapubic pain with fever? Yes/No/don't know
11. Did s/he have difficulty in initiating micturition? Yes/No/don't know
12. Did s/he have weak urine stream or hesitancy? Yes/No/don't know
13. Did s/he have urgency or inability to control urine or dribbling of urine? Yes/No/don't know
14. Please describe the timeline of symptoms from first to last and their pattern and progression ____ ____ ____ ____

F. Questions pertaining to other systems: (If response to Q1 is No/Don't know, skip to Q8)

1. Did s/he have skin rash? Yes/No/don't know (If yes for how long ___________)
2. Which sites were involved? Face/Trunk/Arms and legs/any other place____________
3. What did the rash look like? Measles rash/Rash with clear fluid/Rash with pus/Other/don't know
4. Where did the rash first appear ________________________________
5. How did the rash progress, where did it start, progress and distribute ____
6. What was the type of lesion in the rash? Erythema/nodule/papule/macule/vesicle/pustule/petechiae/ecchymosis/abscess/ulcer/others_____
7. Was the rash associated with any symptom like fever or pruritus? Yes/No/don't know
8. Any history of other joint pain/myalgia? If so specify the site and intensity ___________
9. Did s/he have red eyes? Yes/No/don't know
10. Did s/he have bleeding from mouth/nose/anus? Yes/No/don't know
11. Did s/he ever have shingles or herpes zoster? Yes/No/don't know

12. Did s/he have weight loss? Yes/No/don't know (If yes for how long, specify __________)
13. Did s/he look thin and wasted? Yes/No/don't know
14. Did s/he have mouth sores or white patches in the mouth or tongue? Yes/No/don't know(If yes for how long, specify _________________)
15. Did s/he have any swelling? Yes/No/don't know (If yes for how long___________)
16. Where was the swelling present? Face/Joints/Ankles/Whole body/Any other please specify __________
17. Did s/he have any lumps? Yes/No/don't know (If yes for how long, specify_________
18. Where was the lump present? Neck/Arm pit/ Groin/Any other please specify __________
19. Did s/he have yellow discoloration of eyes? Yes/No/don't know
20. If yes for how long, specify_______________
21. Did s/he look pale (thinning or lack of blood) or have pale palms, eyes or nail beds? Yes/No/don't know
22. If yes for how long, specify ________________
23. Did s/he have an ulcer, abscess or sore anywhere in the body? Yes/No/don't know
24. If yes for how long, specify ___________________
25. Where was the location of the ulcer? ___________________________________

G. Questions pertaining to COVID-19 infection and/or post-COVID vaccination: (If response to Q1 is No/Don't know, skip to Q5)

1. Was s/he diagnosed of COVID-19 by a health professional? Yes/No/don't know (If yes, when, specify_______)
2. Did s/he have a recent test for COVID-19? Yes/No/don't know (If yes, when, specify_______)
3. What was the result (ask for the most recent test if done more than once)?
   Positive/Negative/Unclear/don't know
4. Did s/he experience a new loss, change or decreased sense of smell or taste? Yes/No/don't know
   If yes, when, specify_________________
5. Did s/he suffer from extreme fatigue (felt so tired that s/he found it hard to get out the bed and do the routine things like taking a shower or changing clothes)? Yes/No/don't know
6. Did anyone in the family experience a new loss, change or decreased sense of smell or taste?
   Yes/No/don't know
7. Was anyone in the family diagnosed or suspected of COVID-19 infection? Yes/No/don't know
8. Was anyone in the family tested for COVID-19 infection? Yes/No/don't know (If yes, when, specify_______)
   If yes, who was tested and what was the COVID-19 test result (relationship with the deceased)?
   (Relationship with the deceased ___________)
9. Was anyone in the neighborhood tested positive for COVID-19 infection? Yes/No/don't know (If yes, when, specify_______)

10. In the two weeks before death, did s/he live with, visit, or care for someone who had any COVID-19 symptoms or a positive COVID-19 test (symptoms include fever, difficulty breathing, cough, extreme fatigue, and changes in sense of smell or taste)? Yes/No/don't know
11. In the two weeks before death, did s/he travel to an area where COVID-19 is known to be present? Yes/No/don't know (If yes, when, specify_______)

H. Section 8: Treatment and Health service use during the final illness:

1. Did s/he receive any treatment for the illness that led to death? Yes/No/don't know
2. Can you please list the drugs s/he was given for the illness that led to death (copy/provide the list from the hospital records) ______________________________________
3. What type of treatment did s/he receive? ____
4. Where did s/he receive the treatment? Home/ Traditional healer/ Govt clinic/ Govt hospital/ Private clinic/ Private hospital/ Pharmacy or drug seller store/Other ___________________
5. Did a doctor/health care worker tell you the cause of death? Yes/No/Don't know
6. What did the Doctor/ health care worker say:

7. Did s/he undergo any operation for the illness that led to death? Yes/No/don't know
8. On what part of the body was the operation? _________________________________
9. How long before death did s/he undergo the operation? _________________________

I. Section 9: Risk Factors:

(If response to Q1 is No/Don't know, skip to Q5)

(If response to Q5 is No/Don't know, skip to Q10)

1. Did s/he drink alcohol? Yes/No/don't know(If yes for how long________________)
2. How often did s/he drink alcohol? (Daily____/weekly_____/once a while/don't know)
3. Did s/he stop drinking alcohol? Yes/No/don't know
4. If yes, for how long before death did s/he stop drinking alcohol? _______________
5. Did s/he smoke or chew tobacco? Yes/No/don't know(If yes for how long specify _________)
6. Mention the type of tobacco used: _____________________________
7. How often did s/he smoke or chew tobacco? (Daily____/weekly_____/once a while/don't know)
8. How many cigarettes/beedi did s/he smoke or use chewing tobacco daily? __________

9. Did s/he stop smoking or chewing tobacco before death? Yes/No/don't know
10. Dis s/he use any other addition (sniff/smoke/drugs/other) Yes/No/don't know
    If yes, for how long did s/he use addition please specify___________________
11. How often did s/he use any other addition (sniff/smoke/drugs/other)? (Daily____/weekly_____/once a while/don't know)
12. Did s/he have any exposure to pesticides? Yes/No/don't know
13. Did s/he have exposure to indoor air pollution in terms of biomass fuel use? Yes/No/don't know

J. Section 10: Data abstracted from death certificate

1. Do you have the death certificate of the deceased? Yes/No/don't know
2. Can I see the death certificate (Copy the day, month and year of death from the death certificate) ____
3. Record the cause of death from the first (top) line of death certificate:
4. ____
5. Record the cause of death from the second line of death certificate:
6. ____
7. Record the cause of death from the third line of death certificate:
8. ____
9. Record the cause of death from the fourth line of death certificate:
10. ____

K. Section 11: Data abstracted from other health records

1. Are other health records available? Yes/No
2. Post mortem results (if any) _____________________________
3. MCH/ANC card information _____________________________
4. Hospital prescription information _________________________
5. Hospital discharge summary information ___________________
6. Laboratory results information ____________________________
7. Other Hospital documents information if any ________________
8. Cremation/burial information if any ___________________________
9. Record the time at the end of the interview ___________________

L. Section 12: Miscellaneous

1. How did s/he die? _________________
2. How do you think s/he had died? _________________
3. What was the symptom s/he had before leading to death? __________________
4. Do you know anyone who was with the deceased person just prior to death? ______________

For Individual found dead:

1. Was the autopsy done for the deceased person? (Yes /No) If Yes, date of autopsy__________
2. Where was the body found?
3. What was the time the body was found?
4. What did you see around the body?
5. Did you see anything unusual around the body or on clothes?
6. What was the posture of the body when you saw it?
7. Was there any marks/bruises/injury/frothing/bleeding/fecal matter or any other substance on the body? (If yes please specify_________________________________

M. Section 13: Interviewer's observations (To be filled at the end of the interview):

Any specific comments:

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