PATIENT SCREENING LOG

No	Date of visit	Health insurance (HI) number	Year of birth	Sex	Enrolled (Yes/No) If Yes: provide signature If No, clarify reason	Signature[3]	Phone number	CRP value
1	01/Jun/20	GB4363621010	*1960*	*Male*	*Yes*	*signed*		<10 mg/l
2	…				*No (2, other, clarify)*			
3	…							
4	….							
5	….							
6	…							

NOTE:

(1): Only patients (or patient's legal authorized representative) in the intervention arm who agree to take CRP test will be required to sign in the signature column.

(2): If patients (or patient's legal authorized representative) are not enrolled to perform CRP test, please clarify excluding reasons (for example: (1) patients who referral required, (2) symptoms last more than 2 weeks, (3) don't have HI number, (4) refusal, (5) other, clarify)