

# CHAIN Number [1][0][0][0][1][ ][ ][ ]

Enrolment date \_\_\_/\_\_\_/\_\_\_ Child's Initials \_\_\_ Weight this week \_\_\_ kg Date weighed \_\_\_/\_\_\_/\_\_\_  <6m

Month ___	Date ___						
(24h clock) Time seen	___:___	___:___	___:___	___:___	___:___	___:___	___:___
Oedema now	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N
Oedema improving?	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
For infants under 6m Weigh 48hrly	___ kg	___ kg	___ kg	___ kg	___ kg	___ kg	___ kg

### Clinical Events in the last 24h

<b>DANGER SIGNS at any time in last 24h?</b> <i>If any new danger signs take bloods and record these in sample log. If bloods have been taken by clinical team document results, do not retake bloods</i>	Obstructed breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Respiratory distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shock*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Severe anaemia*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Convulsion(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Severe Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Profuse watery Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vomits everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Impaired Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO DANGER SIGNS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temperature >38°C in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
Temperature <36°C in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
NG tube in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
Any EBM or breastfeeding last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
ReSoMal in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
ORS in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
IV fluids given in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
Blood transfusion in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
Oxygen given in last 24h?	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
CPAP given in last 24h?	Y N	Y N	Y N	Y N	Y N	Y N	Y N	

### Clinical Observations now

In oxygen now	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Oxygen saturation now	___%	___%	___%	___%	___%	___%	___%
Respiratory rate now	___/min	___/min	___/min	___/min	___/min	___/min	___/min
Heart rate now	___/min	___/min	___/min	___/min	___/min	___/min	___/min
AVPU now (circle)	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U
Temperature now	___ . ___ °C	___ . ___ °C	___ . ___ °C	___ . ___ °C	___ . ___ °C	___ . ___ °C	___ . ___ °C
In PICU/ HDU now	Y N	Y N	Y N	Y N	Y N	Y N	Y N
In a surgical or specialist unit now	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on F75/equivalent	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on F100/equivalent	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on RUTF	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on supplementary feed	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Infant formula or dilute F100	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Non-standard milk e.g. soya	Y N	Y N	Y N	Y N	Y N	Y N	Y N



Month ___ ___ Date	___	___	___	___	___	___	___
Currently has an IV cannula?	Y N	Y N	Y N	Y N	Y N	Y N	Y N
<b>IV ANTIMICROBIALS IN LAST 24H</b>							
Crystalline / benzylpenicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gentamicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftriaxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ampicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e.g. augmentin) Co-Amoxiclav	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chloramphenicol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cefotaxime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftazidime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flucloxacilin/Cloxacillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meropenem/Imipenem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pivmecillinam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NO IV ANTIBIOTICS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>ORAL ANTIBIOTICS IN LAST 24H</b>							
Oral Amoxicillin/ampiclox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e.g. augmentin) Co-Amoxiclav	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azithromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Cephalosporin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-trimoxazole <u>treatment</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-trimoxazole <u>prophylaxis</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitrofurantoin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nalidixic acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clindamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metronidazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pivmecillinam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NO ORAL ANTIBIOTICS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>OTHER ANTI-INFECTIVE AGENTS IN LAST 24H</b>							
Anti-malarial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ART	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e.g. fluconazole) Antifungal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-TB treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinician's initials							

