



CHAIN Number [1][0][0][0][3] [ ][ ][ ]

<b>Follow up at 180 days</b> TO BE COMPLETED WITHIN 14 DAYS OF SCHEDULED APPT BY TELEPHONE IF PARTICIPANT UNABLE TO ATTEND. IF PARTICIPANT ATTENDS LATER, AMEND CRF			
DATE SEEN:	____/____/_____ <i>D D / M M / Y Y Y Y</i>	TIME SEEN: 24H Clock	____:____
Seen at:	<input type="checkbox"/> Hospital / clinic <input type="checkbox"/> Seen in community <input type="checkbox"/> Not seen		
If not seen within 2 weeks of scheduled appointment	<input type="checkbox"/> Confirmed alive only e.g. telephoned to confirm vital status	DATE CONTACTED	____/____/_____ <i>D D / M M / Y Y Y Y</i>
	<input type="checkbox"/> Confirmed dead Complete verbal autopsy and study conclusion	DATE CONTACTED	____/____/_____ <i>D D / M M / Y Y Y Y</i>
Not seen within 2 weeks but willing to attend appointment in future <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to contact by telephone or home visit	DATE OF LAST TELEPHONE CALL	____/____/_____ <i>D D / M M / Y Y Y Y</i>
		DATE OF HOME VISIT If patient did not attend and could not be reached by telephone	____/____/_____ <i>D D / M M / Y Y Y Y</i>

<b>Anthropometry and Nutrition</b>			
<b>Weight</b> to be taken using SECA scales for CHAIN	____ . ____ kg	<b>Length</b> to be taken using SECA 416 infantometer provided for CHAIN	Measurer 1 _____ cm
			Measurer 2 _____ cm
<b>MUAC</b> To be taken using MUAC tape for CHAIN	Measurer 1    _____ cm	<b>Head circumference</b> To be taken using CHAIN measuring tape	Measurer 1 _____ cm
	Measurer 2    _____ cm		Measurer 2 _____ cm
<b>Oedema</b> <input type="checkbox"/> None <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++		<b>Initials</b>	Measurer 1                      Measurer 2 _____                      _____



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Current Health					
Child in usual state of health now?	Y	N	If No, length of current illness		Number of days: ____
What symptoms are present now? Select up to 3:					
<input type="checkbox"/> No symptoms, child is well <input type="checkbox"/> Vomiting <input type="checkbox"/> Fever / Hotness of body <input type="checkbox"/> Lethargy <input type="checkbox"/> Diarrhoea <14 days <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Convulsions <input type="checkbox"/> Diarrhoea >14 days <input type="checkbox"/> Cough<14 days <input type="checkbox"/> Altered consciousness <input type="checkbox"/> Blood in stool <input type="checkbox"/> Cough>14days <input type="checkbox"/> Not feeding <input type="checkbox"/> Poor feeding / weight loss <input type="checkbox"/> Body swelling/ oedema <input type="checkbox"/> Rash / skin lesion					
Medication last 7 days. Circle any that apply	<input type="checkbox"/> No medication	<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Antimalarial	<input type="checkbox"/> Deworming	<input type="checkbox"/> Multivitamin
	<input type="checkbox"/> Zinc	<input type="checkbox"/> Iron supplement	<input type="checkbox"/> Vitamin D/ Calcium	<input type="checkbox"/> Traditional / herbal / homeopathy	<input type="checkbox"/> Paracetamol/ Ibuprofen
	<input type="checkbox"/> ORS	<input type="checkbox"/> Antihistamine		<input type="checkbox"/> Yes, but unknown	

HOSPITAL ADMISSIONS			
Any admissions (e.g. overnight stay) to a hospital since discharge?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If Yes: Admission date (estimate)	Hospital Name	Length of stay (days)	Source of information
____/____/____ D D / M M / Y Y Y Y		____	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
____/____/____ D D / M M / Y Y Y Y		____	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report



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Outpatient Appointments		
Participant attended outpatient appointment since discharge?		
Nutrition follow-up only	Y	N
General paediatric appointment	Y	N
Cardiology appointment	Y	N
Neurology appointment	Y	N
HIV clinic	Y	N
TB clinic	Y	N
Sickle cell or thalassaemia clinic	Y	N
Outpatient blood transfusion	Y	N
Specialist Radiology	Y	N
Other specialist paediatric appointment	Y	N

Caregiver Appointments / Admissions		
<input type="checkbox"/> No outpatient appointment	<input type="checkbox"/> Not applicable – child in care	
Caregiver admitted to hospital since last appointment?	Y	N
Psychiatry follow-up	Y	N
Antenatal care	Y	N
HIV clinic	Y	N
TB clinic	Y	N
Other	Y	N

Feeding			
<b>Currently in outpatient nutrition program?</b> <i>Select one. If not in feeding program circle 'none'</i>	<input type="checkbox"/> Supplementary <i>(corn soy blend, RUSF, khichuri, halwa etc)</i>	<input type="checkbox"/> Therapeutic <i>(RUTF, Plumpy-nut)</i>	<input type="checkbox"/> None
<b>Has the child eaten these nutrition products in the last 3 days?</b>	<input type="checkbox"/> Supplementary	<input type="checkbox"/> Therapeutic	<input type="checkbox"/> None
<b>Currently Breastfeeding?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>If yes, taking other foods/fluids?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If NO breastfeeding at all, age stopped (in months)?</b> <i>Select one</i>	<input type="checkbox"/> 0-3m	<input type="checkbox"/> 4-6m <input type="checkbox"/> 7-12m	<input type="checkbox"/> >12m <input type="checkbox"/> Unknown



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Vaccinations – Ask carer or check book / card if available							
BCG scar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rotavirus	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
	Measles	<input type="checkbox"/> Book <input type="checkbox"/> Self report <input type="checkbox"/> Not received <input type="checkbox"/> Unknown	Pneumococcus	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
DTP/Penta			<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown	
Polio			<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown	

TB Screening							
Known TB (on treatment)		Child has cough >14 days		Household contact has TB, or cough >14 days		Child has suspected extrapulmonary TB	
Y	N	Y	N	Y	N	Y	N

### Complete Study Conclusion

CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i>	_____	Date	Time
	_____	___/___/_____ D D / M M / Y Y Y Y	____:____