



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

| Follow up at 45 days 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 | ___:___ |
| Informed consent reviewed with caregiver | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 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"/> Unable to contact by telephone or home visit | DATE OF LAST TELEPHONE CALL | ___/___/_____ <i>D D / M M / Y Y Y Y</i> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | 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> |

| Anthropometry and Nutrition | | | |
|--|---|---|--|
| Weight to be taken using SECA scales for CHAIN | ___ ___ . ___ ___ kg | Length to be taken using SECA 416 infantometer provided for CHAIN | Measurer 1 _____ . _____ cm |
| | | | Measurer 2 _____ . _____ cm |
| MUAC To be taken using MUAC tape for CHAIN | Measurer 1 _____ . _____ cm | Head circumference To be taken using CHAIN measuring tape | Measurer 1 _____ . _____ cm |
| | Measurer 2 _____ . _____ cm | | Measurer 2 _____ . _____ cm |
| Oedema | <input type="checkbox"/> None <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++ | Initials | 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? <i>Select up to 3:</i> | | | | | |
| <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. <i>Circle any that apply</i> | <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 |
| ____/____/____ <i>D D / M M / Y Y Y Y</i> | | ____ | <input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report |
| ____/____/____ <i>D D / M M / Y Y Y Y</i> | | ____ | <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 | | | |
|---|--|---|--|
| Currently in outpatient nutrition program? <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 |
| Has the child eaten these nutrition products in the last 3 days? | <input type="checkbox"/> Supplementary | <input type="checkbox"/> Therapeutic | <input type="checkbox"/> None |
| Currently Breastfeeding? | <input type="checkbox"/> Y <input type="checkbox"/> N | If yes, taking other foods/fluids? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| If NO breastfeeding at all, age stopped (in months)? <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 | Pneumococcus | <input type="checkbox"/> Book | <input type="checkbox"/> Self report | <input type="checkbox"/> Not received |
| <input type="checkbox"/> Not received | | <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 |

Inform caregiver there will be samples taken at next visit.

| Plan day 90 visit | |
|---|--|
| Date of next visit <div style="text-align: center;"> __/__/____ D D/M M/ Y Y Y Y </div> | Any new contact details: Explained to parent that samples will be collected at next visit <input type="checkbox"/> Y <input type="checkbox"/> N |

| | | | |
|---|-------|--|------------------------|
| CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i> | _____ | Date <div style="text-align: center;"> __/__/____ D D / M M / Y Y Y Y </div> | Time ____: ____ |
| | _____ | _____ | _____ |