



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 | ____:____ |
| 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> |

| 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 _____ _____ |



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

| 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 |



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

| 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 |

Plan day 180 Follow Up Date

___/___/_____
D D / M M / Y Y Y

| | | | |
|---|-------|--------------------------------------|-----------|
| 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 | ____:____ |