

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



Eligibility Checklist		
Age between 7 days and 59 days after date of birth	Y	N - ineligible
Being admitted to hospital because of acute illness	Y	N- ineligible
Parent or guardian able and available to consent	Y	N- ineligible
Able to feed orally in usual state of health	Y	N- ineligible
Known congenital syndrome	Y- ineligible	N
Cleft palate	Y- ineligible	N
Known congenital cardiac disease	Y- ineligible	N
Known terminal illness e.g. cancer	Y- ineligible	N
Admission for surgery, or likely to require surgery within 6m	Y- ineligible	N
Admission for trauma?	Y- ineligible	N
Sibling enrolled in study	Y- ineligible	N
Previously enrolled	Y- ineligible	N

Part 1

1. Admission to Hospital and Study Enrolment

DATE arrived at the hospital	___/___/___ <i>D D / M M / Y Y Y Y</i>	TIME arrived at the hospital	__:__:__ <i>24h Clock</i>	<input type="checkbox"/> Arrival time unknown	
DATE of enrolment i.e. date consented and seen by research team	___/___/___ <i>D D / M M / Y Y Y Y</i>	TIME of enrolment	__:__:__ <i>24h Clock</i>	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
DOB	___/___/___ <i>D D / M M / Y Y Y Y</i>	Is the DOB:	<input type="checkbox"/> True <input type="checkbox"/> Estimated*	Child's Initials	___-___-___
Brought into hospital by: <i>Select all that apply</i>	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle	
	<input type="checkbox"/> Sibling <18	<input type="checkbox"/> Sibling >18	<input type="checkbox"/> Carer (care home)	<input type="checkbox"/> Other _____	

*if DOB is estimated, and the day is uncertain, write '15' for DD

2. Presenting Complaints

<input type="checkbox"/> Fever / Hotness of body	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Lethargy
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Diarrhoea <14 days	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Cough<14 days	<input type="checkbox"/> Diarrhoea >14 days	<input type="checkbox"/> Altered consciousness
<input type="checkbox"/> Cough>14days	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Not feeding
<input type="checkbox"/> Poor feeding/ Weight loss	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Body swelling / limb swelling/ Oedema
<input type="checkbox"/> Rash/ skin lesion	<input type="checkbox"/> Neonatal jaundice	<input type="checkbox"/> Umbilical infection
<input type="checkbox"/> Other (<i>only one complaint, if not covered by above options</i>)		

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3. Initial Observations (to be taken at time of examination by research team)			
Axillary temperature	_____. ____ °C	Respiratory rate Count for 1 minute	_____/minute
Heart rate Count for 1 minute	_____/minute		
SaO2 To be taken from finger or toe using pulse oximeter	_____% Write 000 if unrecordable	<input type="checkbox"/> Measured in Oxygen	<input type="checkbox"/> Measured in Room Air <input type="checkbox"/> Unrecordable

4. Anthropometry					
Weight to be taken using SECA scales for CHAIN study	____. ____ kg		Length to be taken using SECA 416 infantometer provided for CHAIN study	Measurer 1	____. ____ cm
				Measurer 2	____. ____ cm
MUAC To be taken using MUAC tape for CHAIN study	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
				____	____

NB: If the child is unwell the Length can be taken at a later time.

5. Current Health	
Previously admitted to hospital. Include other hospitals / health centres. Select 1	<input type="checkbox"/> No <input type="checkbox"/> < 1 week ago <input type="checkbox"/> 1 weeks-1month ago <input type="checkbox"/> >1month ago
Any medication last 7 days. Select all that apply	<input type="checkbox"/> No medication <input type="checkbox"/> Antibiotic <input type="checkbox"/> Antimalarial <input type="checkbox"/> Traditional <input type="checkbox"/> Deworming <input type="checkbox"/> Vitamin <input type="checkbox"/> Paracetamol or Ibuprofen <input type="checkbox"/> Yes, but unknown <input type="checkbox"/> Other
Urine volume in last 24hrs? Select 1	<input type="checkbox"/> Not passing urine <input type="checkbox"/> Less than normal <input type="checkbox"/> Normal or greater <input type="checkbox"/> Unknown

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6. Examination

Examination should be performed by CHAIN study clinician trained in clinical examination of children, and able to formulate a diagnosis based on clinical history and findings. Refer to Clinical Examination SOP

Airway <i>(select one)</i>	<input type="checkbox"/> Clear	<input type="checkbox"/> Needs active support	<input type="checkbox"/> Obstructed/Stridor
Breathing <i>(select all that apply)</i>	<input type="checkbox"/> Normal – no concerns , (move to circulation) <input type="checkbox"/> Central cyanosis <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Reduced air-entry <input type="checkbox"/> Wheeze <input type="checkbox"/> Acidotic Breathing <input type="checkbox"/> Grunting <input type="checkbox"/> Lower chest wall indrawing <input type="checkbox"/> Crackles <input type="checkbox"/> Dull to percussion <input type="checkbox"/> Head nodding		
Circulation:			
Cap Refill (select one)	<input type="checkbox"/> >3s	<input type="checkbox"/> 2-3s	<input type="checkbox"/> <2s
Cold Peripheries (select one)	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hand <input type="checkbox"/> Warm peripheries
Disability:			
Conscious level (select one)	<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive
Fontanelle (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Bulging	<input type="checkbox"/> Sunken <input type="checkbox"/> Not present
Tone (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Hypertonic	<input type="checkbox"/> Hypotonic
Posture (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Decorticate	<input type="checkbox"/> Decerebrate
Activity (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Irritable/Agitated	<input type="checkbox"/> Lethargic
Dehydration:			
Sunken eyes?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Skin pinch (select one)	<input type="checkbox"/> >2 seconds	<input type="checkbox"/> <2 seconds	<input type="checkbox"/> Immediate
Drinking/Breastfeeding <i>(Select one)</i>	<input type="checkbox"/> Normal	<input type="checkbox"/> Poorly	<input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
Abdomen <i>(select any that apply)</i>	<input type="checkbox"/> Normal – no concerns	<input type="checkbox"/> Distension	<input type="checkbox"/> Hepatomegaly
	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Splenomegaly	<input type="checkbox"/> Other abdominal mass
Signs of Rickets	<input type="checkbox"/> None	<input type="checkbox"/> Wrist widening	<input type="checkbox"/> Rachitic rosary <input type="checkbox"/> Swollen knees <input type="checkbox"/> Bow legs <input type="checkbox"/> Frontal bossing
Jaundice (Select one)	<input type="checkbox"/> Not jaundiced	<input type="checkbox"/> +	<input type="checkbox"/> ++ <input type="checkbox"/> +++
ENT/Oral/Eyes <i>(select any that apply)</i>	<input type="checkbox"/> Mouth Normal	<input type="checkbox"/> Ears Normal	<input type="checkbox"/> Eyes Normal
	<input type="checkbox"/> Oral ulceration	<input type="checkbox"/> Pus from ear	<input type="checkbox"/> Conjunctivitis
	<input type="checkbox"/> Oral candidiasis	<input type="checkbox"/> Tender swelling behind ear (mastoiditis)	<input type="checkbox"/> Eye discharge
	<input type="checkbox"/> Stomatitis	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Visual impairment
Skin <i>(select any that apply)</i>	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> Depigmentation
	<input type="checkbox"/> Broken skin/excoriation	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> 'Flaky paint'
	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Impetigo	<input type="checkbox"/> Pustules
	<input type="checkbox"/> Vesicles	<input type="checkbox"/> Desquamation	<input type="checkbox"/> Macular or papular
Site of skin lesions. <i>(select any that apply)</i>	<input type="checkbox"/> Not applicable (No rash)	<input type="checkbox"/> Trunk	<input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs
	<input type="checkbox"/> Palms / soles	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Arms <input type="checkbox"/> Perineum

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7. Suspected Chronic Conditions

Select confirmed, suspected or none for all conditions:	Confirmed (diagnosed previously/ recorded)	Suspected (clinician's impression)	None
Cerebral palsy/neurological problem/ epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell disease <i>family history, crisis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thalassaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual problem / Blindness <i>Not fixing and following</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losing weight or not gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Feeding

Currently Breastfeeding?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes is the child taking anything else (exclude medicine)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
What did the child receive other than breast milk in the first 3 days of life? <i>Select all that apply</i> <i>Do not include medications e.g. ARV.</i>	<input type="checkbox"/> Sweetened/sugar water <input type="checkbox"/> Fruit Juice <input type="checkbox"/> Water <input type="checkbox"/> Pure Honey	<input type="checkbox"/> Formula/powder milk <input type="checkbox"/> Tea <input type="checkbox"/> Porridge/pulp <input type="checkbox"/> Glycerine	<input type="checkbox"/> Animal milk <input type="checkbox"/> Other <input type="checkbox"/> Gutthi / gripe water <input type="checkbox"/> Nothing

11. Immediate Clinical Investigations and HIV status

Malaria RDT <i>circle result</i>	Positive	Negative	Not done
Blood glucose	____ . ____ mmol/L	Time glucose measured	____ : ____ 24h clock <input type="checkbox"/> Unknown
HIV status known?	<input type="checkbox"/> Yes, known PCR positive <input type="checkbox"/> Yes, antibody positive, unknown PCR status <input type="checkbox"/> Yes, known exposed, known PCR negative (children under 18m with PCR result SEEN BY RESEARCH TEAM. If not seen select below and perform HIV RDT <input type="checkbox"/> No, known to be HIV exposed, but child untested <input type="checkbox"/> No, child not tested, not known to be exposed		
If child known HIV positive or exposed	On any ART?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown If on treatment, ARV 1 _____ ARV 2 _____ ARV 3 _____	If on prophylaxis <input type="checkbox"/> Nevirapine prophylaxis only <input type="checkbox"/> AZT + NVP prophylaxis <input type="checkbox"/> Caregiver unsure
	Co-trimoxazole <i>select one</i>	<input type="checkbox"/> On prophylactic dose co-trimoxazole <input type="checkbox"/> On high dose co-trimoxazole <input type="checkbox"/> Not on co-trimoxazole	<input type="checkbox"/> Caregiver unsure

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If not known positive	HIV RDT now <i>select one</i>	<input type="checkbox"/> Reactive / positive	<input type="checkbox"/> Non-Reactive / Negative	<input type="checkbox"/> Declined
		PCR sent: <input type="checkbox"/> Y <input type="checkbox"/> N		
Referred to HIV clinic		<input type="checkbox"/> Yes <input type="checkbox"/> No (select 'No' if referral not indicated)		
HIV test offered to caregiver?		<input type="checkbox"/> Yes, Reactive	<input type="checkbox"/> Yes, Non-reactive	<input type="checkbox"/> Yes, but Declined
		<input type="checkbox"/> No, Caregiver is known positive	<input type="checkbox"/> Missed	<input type="checkbox"/> N/A child in care home
Did the mother have interventions or medication during delivery to prevent transmission of HIV to baby?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Birth and perinatal care

Born in THIS hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not born in hospital <input type="checkbox"/> Unknown
Stayed more than one night in hospital after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
Risk factors for complications	<input type="checkbox"/> None known <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Fever / unwell in labour <input type="checkbox"/> Breech presentation <input type="checkbox"/> Membranes ruptured >24h before birth <input type="checkbox"/> Premature labour <input type="checkbox"/> Offensive liquor/vaginal discharge <input type="checkbox"/> Unknown
Mother received medication during labour and delivery? <i>Select all that apply</i>	<input type="checkbox"/> No medication <input type="checkbox"/> Unknown <input type="checkbox"/> General anaesthetic <input type="checkbox"/> IV antibiotic <input type="checkbox"/> Steroid (premature labour) <input type="checkbox"/> Epidural /spinal <input type="checkbox"/> Traditional/herbal/ homeopathy <input type="checkbox"/> PMTCT <input type="checkbox"/> Misoprostol / induction of labour <input type="checkbox"/> Analgesia <input type="checkbox"/> Oxytocin <input type="checkbox"/> Antacid <input type="checkbox"/> Other <input type="checkbox"/> Yes but unknown

Antenatal care received

Source of information <i>Select all that apply</i>	<input type="checkbox"/> None
	<input type="checkbox"/> Maternal recall <input type="checkbox"/> Health record book <input type="checkbox"/> Other relative recall
Antenatal care received? <i>Select one</i> <i>Antenatal appointment includes any scheduled at health centre, visits in the community or organised privately. These must be for pregnancy not other medical issues</i>	<input type="checkbox"/> No antenatal care <input type="checkbox"/> At least 1 antenatal appointment <input type="checkbox"/> 2 antenatal appointments <input type="checkbox"/> More than 2 appointments <input type="checkbox"/> Unknown
Ultrasound scan? <i>Select one</i>	<input type="checkbox"/> None <input type="checkbox"/> At least one <input type="checkbox"/> More than one <input type="checkbox"/> Unknown

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Does the mother have any help with breast feeding? <i>Select all that apply. 'Relative' refers to relative of the child. Ask the mother if she feels there is active and positive support of breast feeding</i>	<input type="checkbox"/> No support with breast feeding <input type="checkbox"/> Yes maternal relative <input type="checkbox"/> Yes paternal relative <input type="checkbox"/> Yes father <input type="checkbox"/> Yes midwife/ community health worker <input type="checkbox"/> Yes other
Does the mother/caregiver intend to continue breast feeding once the baby is over 6m old?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
NO, Not breastfeeding at all now (if mother not intending to breastfeed) Has the child ever breast fed since birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Why has breastfeeding stopped? <i>Select one, the main reason</i>	<input type="checkbox"/> Mother HIV positive <input type="checkbox"/> Not enough milk <input type="checkbox"/> Baby struggled to breastfeed <input type="checkbox"/> Mother unwell <input type="checkbox"/> Mother died, not present <input type="checkbox"/> Other
Does the mother have any help with feeding? <i>Select all that apply. 'Relative' refers to relative of the child.</i>	<input type="checkbox"/> No support with feeding <input type="checkbox"/> Yes maternal relative <input type="checkbox"/> Yes paternal relative <input type="checkbox"/> Yes father <input type="checkbox"/> Yes midwife/ community health worker <input type="checkbox"/> Yes other
Does the mother/caregiver have any help with the baby? <i>Select all that apply. 'Relative' refers to relative of the child</i>	<input type="checkbox"/> No help <input type="checkbox"/> Yes maternal relative
	<input type="checkbox"/> Yes paternal relative <input type="checkbox"/> Yes father <input type="checkbox"/> Yes midwife /community health worker <input type="checkbox"/> Yes other
Does the caregiver buy other sources of milk for the baby? <i>Select all that apply</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes infant formula <input type="checkbox"/> Yes other breast milk <input type="checkbox"/> Yes cows milk <input type="checkbox"/> Yes other
Was the mother working prior to giving birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Is the mother working now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Maternity pay?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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11. Suspected Initial Diagnoses:

c Clinical diagnosis should be based on examination and investigation findings.

Tick the three most likely diagnoses.

Respiratory	Infection	CNS
<input type="checkbox"/> LRTI/pneumonia	<input type="checkbox"/> Gastroenteritis	<input type="checkbox"/> Febrile convulsions
<input type="checkbox"/> Bronchiolitis	<input type="checkbox"/> Sepsis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> URTI	<input type="checkbox"/> Malaria	<input type="checkbox"/> Probable meningitis
<input type="checkbox"/> Pulmonary TB	<input type="checkbox"/> Extra pulmonary TB	<input type="checkbox"/> Other encephalopathy
<input type="checkbox"/> Otitis media	<input type="checkbox"/> Soft tissue infection	<input type="checkbox"/> Hydrocephalus
<input type="checkbox"/> Asthma	<input type="checkbox"/> UTI	<input type="checkbox"/> Developmental delay
General	<input type="checkbox"/> HIV related illness	<input type="checkbox"/> Cerebral palsy / Birth asphyxia
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Measles	Other suspected diagnosis:
<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Varicella	<input type="checkbox"/> Other
<input type="checkbox"/> Thalassaemia	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Unknown
<input type="checkbox"/> Renal impairment	<input type="checkbox"/> Febrile illness unspecified	<input type="checkbox"/> Failed appetite test only
<input type="checkbox"/> Nephrotic syndrome	<input type="checkbox"/> Enteric fever	<input type="checkbox"/> Breast-feeding difficulty
<input type="checkbox"/> Nephritis	<input type="checkbox"/> Infected umbilicus	<input type="checkbox"/> Tongue tie
<input type="checkbox"/> Liver dysfunction		<input type="checkbox"/> Congenital syphilis
<input type="checkbox"/> Ileus		<input type="checkbox"/> Microcephaly
<input type="checkbox"/> Congenital cardiac disease		
<input type="checkbox"/> Haemolytic disease newborn		
<input type="checkbox"/> Neonatal jaundice		

12 Initial Treatment

Admitted to: <i>select one</i>	<input type="checkbox"/> Admission to ward	<input type="checkbox"/> Admission to HDU	<input type="checkbox"/> Admission to ICU	<input type="checkbox"/> Admission to neonatal unit
Date and time First antibiotics given	___/___/____			___:___ <input type="checkbox"/> Not given
Intravenous Antibiotics Given?	<input type="checkbox"/> Benzylpenicillin	<input type="checkbox"/> Gentamicin	<input type="checkbox"/> Ceftriaxone / Cefotaxime	
<input type="checkbox"/> Not given	<input type="checkbox"/> Co-amoxiclav/ Augmentin	<input type="checkbox"/> Flu/Cloxacillin	<input type="checkbox"/> Chloramphenicol	
	<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Amikacin	<input type="checkbox"/> Meropenem / Imipenem	
	<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Vancomycin	<input type="checkbox"/> Metronidazole	
	<input type="checkbox"/> Ceftazidime	<input type="checkbox"/> Pivmecillinam		

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	<input type="checkbox"/> Other _____			
Oral Antibiotics Given? <input type="checkbox"/> Not given	<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Azithromycin	
	<input type="checkbox"/> Co-trimoxazole	<input type="checkbox"/> Metronidazole	<input type="checkbox"/> Ciprofloxacin	
	<input type="checkbox"/> Cefalexin / cefaclor	<input type="checkbox"/> Co-amoxiclav / Augmentin	<input type="checkbox"/> Nalidixic acid	
	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Flucloxacillin	<input type="checkbox"/> Levofloxacin	
	<input type="checkbox"/> Other _____			
Initial treatment given <i>First 6 hours.</i> <i>Select any that apply.</i>	<input type="checkbox"/> IV Fluid Bolus	<input type="checkbox"/> IV Maintenance Fluids		
	<input type="checkbox"/> Oxygen	<input type="checkbox"/> CPAP		
	<input type="checkbox"/> IV Glucose	<input type="checkbox"/> Oral Glucose	<input type="checkbox"/> Warmth (heater, warmed fluids)	
	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Commercial F75		
	<input type="checkbox"/> Phenobarbitone	<input type="checkbox"/> Commercial F100		
	<input type="checkbox"/> Diazepam	<input type="checkbox"/> Locally prepared F75/ milk suji		
	<input type="checkbox"/> Paracetamol	<input type="checkbox"/> Local prepared F100 / milk suji 100		
	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Expressed breast milk		
	<input type="checkbox"/> Diclofenac	<input type="checkbox"/> Dilute F100/ dilute milk or formula		
	<input type="checkbox"/> Salbutamol / atrovent / other bronchodilator	<input type="checkbox"/> Other milk/ formula/ feed		
	<input type="checkbox"/> Prednisolone/ dexamethasone/ hydrocortisone	<input type="checkbox"/> RUTF		
	<input type="checkbox"/> Adrenaline	<input type="checkbox"/> Nasogastric tube		
	<input type="checkbox"/> Zinc	<input type="checkbox"/> Multivitamin		
	<input type="checkbox"/> Folic acid	<input type="checkbox"/> Micronutrients		
	<input type="checkbox"/> Antimalarial (any)	<input type="checkbox"/> Vitamin A		
	<input type="checkbox"/> ReSoMal	<input type="checkbox"/> Albendazole / deworming		
	<input type="checkbox"/> ORS	<input type="checkbox"/> Other _____		

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11. Admission Core Cohort Investigations and Sample Collection

CBC taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Plain Blood (serum)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Clinical chemistry taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood spot taken	<input type="checkbox"/> Y	<input type="checkbox"/> N
EDTA 2ml blood taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood culture taken <i>(if available at site)</i>	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> Y AFTER ABX	<input type="checkbox"/> N
EDTA 0.5ml blood taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood gas taken <i>(if available at site)</i>	<input type="checkbox"/> Capillary <input type="checkbox"/> Venous	<input type="checkbox"/> N
Date Taken	Date taken _____ Time taken _____: <i>D D / M M / Y Y Y Y</i>				
Unable to take blood samples, why?	<input type="checkbox"/> Difficult venepuncture <input type="checkbox"/> Child uncooperative <input type="checkbox"/> Parent refused <input type="checkbox"/> Other				
Rectal swabs taken	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> Y AFTER ABX	<input type="checkbox"/> N	Number taken <input type="checkbox"/> 1 <input type="checkbox"/> 2	Time taken _____: _____	
Stool sample	Taken in first 24h? <input type="checkbox"/> Y <input type="checkbox"/> N	Date taken _____ <i>D D / M M / Y Y Y Y</i>			Time taken _____: _____

Chest x-ray indicated <i>(respiratory signs symptoms)</i>	<input type="checkbox"/> Yes, but too unwell	<input type="checkbox"/> Yes, done	<input type="checkbox"/> Indicated but not done, unclear	<input type="checkbox"/> Not indicated
Lumbar puncture indicated <i>(signs of meningitis documented)</i>	<input type="checkbox"/> Yes, but too unwell	<input type="checkbox"/> Yes, done	<input type="checkbox"/> Not indicated	

Blood Samples taken by (initials)	_____
Rectal Swabs taken by (initials)	_____

CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i>	_____	Date _____/_____/_____ <i>D D / M M / Y Y Y Y</i>	Time _____:_____
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PART 2

12. CHAIN ADMISSION CRF: SOCIAL INFORMATION.

To be completed within 48h of admission when child is stable. This should ideally be done in a conversational and unhurried way, with the interviewer sitting with the caregiver.

Initials of person interviewing caregiver and completing part 2 ____		Date ____/____/____ D D / M M / Y Y Y Y
<input type="checkbox"/> Doctor <input type="checkbox"/> Clinical officer <input type="checkbox"/> Nurse <input type="checkbox"/> Field worker <input type="checkbox"/> Research Assistant <input type="checkbox"/> Other		Time ____:____
Who is being interviewed?		
<input type="checkbox"/> Primary caregiver only	<input type="checkbox"/> Care home staff	<input type="checkbox"/> Primary caregiver and one other person <input type="checkbox"/> Primary caregiver and more than one other person <input type="checkbox"/> One person who is not the primary caregiver <input type="checkbox"/> More than one person who is not the primary caregiver

13. Care-seeking Behaviour

Was the child in generally good health before this illness?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
If No, how long has the child had this problem of generally bad health?	____ weeks	<input type="checkbox"/> N/A	
Does the child have health insurance?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
What was the main reason for bringing the child to this hospital today? Reasons given, select one			
<input type="checkbox"/> Referred by health care worker	<input type="checkbox"/> Caregiver concern of child's condition	<input type="checkbox"/> Received money for transport to hospital (e.g. from family, neighbour, paid work)?	
<input type="checkbox"/> Relative / neighbour concern of child's condition	<input type="checkbox"/> Primary caregiver returned home e.g. if working away	<input type="checkbox"/> Other	
How did you travel to the hospital? Select all that apply			
<input type="checkbox"/> Car/ Taxi	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Bus	<input type="checkbox"/> Motorbike <input type="checkbox"/> Tuk-tuk /CNG <input type="checkbox"/> Cycle rickshaw <input type="checkbox"/> Train <input type="checkbox"/> Walking <input type="checkbox"/> Other
How long did it take you to travel to hospital?	<input type="checkbox"/> <1h	<input type="checkbox"/> 1- < 2h	<input type="checkbox"/> 2-4h <input type="checkbox"/> >4h <input type="checkbox"/> > 1 day
How much did it cost the family to travel to hospital today (in local currency)? Estimate amount. If walked, drove own car or free ambulance write	_____		
Have you sought treatment for this illness prior to coming to hospital? Select all that apply			
<input type="checkbox"/> No treatment sought	<input type="checkbox"/> Shop	<input type="checkbox"/> Government hospital	<input type="checkbox"/> Government dispensary <input type="checkbox"/> Traditional Healer
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Private Medical Facility/ NGO	<input type="checkbox"/> Herbalist	<input type="checkbox"/> Homeopathist <input type="checkbox"/> Other
Received treatment from traditional healer, homeopathist or herbalist in last 4 weeks?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
14. Child's Health Status Before Admission			
Before this illness, how did this child's health compare to other children of similar age in your neighbourhood? Select one			
<input type="checkbox"/> Similar	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Don't know
Before this illness, how did this child's health compare to his/her siblings at a similar age? Select one			
<input type="checkbox"/> Similar	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Don't know <input type="checkbox"/> N/A only child

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11. Primary Caregiver Information					
<i>This is the person who has responsibility for day to day care of the child, but is not a substitute carer such as childminder or grandparent who cares for child whilst, for example, mother is at work.</i>					
Who is the Primary Caregiver? <i>Select one</i>	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt / Uncle / Cousin <input type="checkbox"/> Stepmother / father <input type="checkbox"/> Care home /orphanage <input type="checkbox"/> Other/ Unclear				
Is the child's biological father alive?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	Is the child's biological mother alive?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown		
Primary Care Giver Age <i>Select one</i>	<input type="checkbox"/> <18years <input type="checkbox"/> >=18 years <input type="checkbox"/> >50years <input type="checkbox"/> N/A (care home or unclear)				
Primary Care Giver Sex <i>Select one</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> N/A	Primary caregiver present at admission?		<input type="checkbox"/> Y <input type="checkbox"/> N	
Has the primary caregiver lived in the same household as the child for the last 2 months?				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> N/A (care home)
Marital status of primary caregiver <i>Select one</i>	<input type="checkbox"/> Married/ monogamous	<input type="checkbox"/> Married polygamous	<input type="checkbox"/> Single	<input type="checkbox"/> Separated / divorced	<input type="checkbox"/> Widowed <input type="checkbox"/> N/A
If not present at admission, where is the primary caregiver? <i>Select one</i>					
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A					
If the primary caregiver is present, caregiver anthropometry:					
<i>Use locally available adult scales and stadiometer, and adult MUAC tapes provided by CHAIN.</i>					
<input type="checkbox"/> Primary caregiver not present during admission, or care home					
Weight	_____ kg	MUAC	_____ cm	Height:	_____ cm
Education: <i>Select highest level of education achieved</i>	<input type="checkbox"/> None <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Above secondary <input type="checkbox"/> Unknown <input type="checkbox"/> N/A care home				
Able to read?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	Is the primary caregiver primarily responsible for financial support and providing for the child?		<input type="checkbox"/> Y <input type="checkbox"/> N	
Primary caregiver HIV status in last 6 months <i>Select one</i>	<input type="checkbox"/> Tested Positive <input type="checkbox"/> Tested Negative <input type="checkbox"/> Not tested or unknown				
Have there been ANY changes to the child's social situation in the last 2 MONTHS? <i>Select any that apply,</i>					
Child moved to a different household	Y N	Relocation from rural to urban setting <i>Select 'yes' even if this is temporary</i>		Y	N
		Relocation from urban to rural setting <i>Select 'yes' even if this is temporary</i>		Y	N
		Relocation to live with different caregiver <i>Select 'yes' even if this is temporary</i>		Y	N
Mother sick	Y N	Mother Died		Y	N
Father sick	Y N	Father Died		Y	N
Other primary caregiver sick	Y N N/A	Other primary caregiver died		Y	N N/A
Primary caregiver changed	Y N	Child went into care home		Y	N
Primary caregiver started employment / returned to school	Y N	Person providing for the child has lost income		Y	N
Primary caregiver divorced / separated from partner	Y N	Primary caregiver in new relationship		Y	N

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Mother is pregnant	Y	N	Mother gave birth	Y	N
Other primary caregiver pregnant?	Y	N	N/A	Other primary caregiver gave birth	Y N N/A
If primary caregiver has changed in the last 2 months, who was the child's previous primary caregiver? <i>Select one</i>					
<input type="checkbox"/> Biologic Mother	<input type="checkbox"/> Biologic Father		<input type="checkbox"/> Sibling ≥18 years old	<input type="checkbox"/> Sibling <18 years old	
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle/Cousin		<input type="checkbox"/> Other	<input type="checkbox"/> N/A	

12. Birth History

Source of information	<input type="checkbox"/> Maternal/caregiver recall		<input type="checkbox"/> Book/medical records		
Birth weight	___ . ___ ___ kg		<input type="checkbox"/> Unknown		
Birth details <i>Select any that apply</i>	<input type="checkbox"/> Premature	<input type="checkbox"/> Born small <2.5kg	<input type="checkbox"/> Twin/multiple birth	<input type="checkbox"/> Born at term	<input type="checkbox"/> Unknown
Delivery location <i>Select one</i>	<input type="checkbox"/> Born in hospital		<input type="checkbox"/> Community facility/clinic with midwife/nurse midwife/doctor		
	<input type="checkbox"/> Home without birth attendant	<input type="checkbox"/> Home with traditional birth attendant (untrained)	<input type="checkbox"/> Home with midwife/nurse		
	<input type="checkbox"/> Other		<input type="checkbox"/> Unknown		
Delivery details <i>Select all that apply</i>	<input type="checkbox"/> Normal, spontaneous vaginal delivery		<input type="checkbox"/> Assisted delivery (forceps, ventouse)	<input type="checkbox"/> Caesarean section	
	<input type="checkbox"/> Admitted neonatal unit		<input type="checkbox"/> Mother admitted to hospital >48h	<input type="checkbox"/> Unknown	
Mother's age at first pregnancy	___ years <input type="checkbox"/> unknown		Mother's age now	___ years	<input type="checkbox"/> unknown
Participant birth order	___ of ___ total live births <i>(e.g. if youngest of 3 children 3 of 3, if oldest of 3 children 1 of 3)</i>				
Are the biological parents of this child consanguineous? <i>Ask if parents have relatives in common or are related.</i>	<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Unknown

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13. Household Food Security (if child in care home include children in the care home only)		
During the past 7 DAYS has ANY member of the household missed a meal due to food shortage?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
During the past 4 WEEKS		
Did you worry that your household would not have enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Were any of your household unable to eat the kinds of food preferred because of a lack of resources?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household had to eat a limited variety of food due to lack of resources?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household eaten some foods that you really didn't want to eat because of lack of resources?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household eaten fewer meals in a day because there was not enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Did household members go to sleep at night hungry because there was not enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Did you or your household members go a whole day and night without eating anything because there was not enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown

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