

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



Discharge Details			
Date discharged by medical team:	___/___/_____ <i>D D / M M / Y Y Y Y</i>	Time discharged by medical team 24H clock	__:__:__ <input type="checkbox"/> Unknown
Discharged against medical advice	<input type="checkbox"/> Y <input type="checkbox"/> N	Absconded	<input type="checkbox"/> Y <input type="checkbox"/> N
Discharged early because of e.g. staff strike, hospital closure	<input type="checkbox"/> Y <input type="checkbox"/> N	Discharged unexpectedly, returned for review	<input type="checkbox"/> Y <input type="checkbox"/> N
Discharged from referral hospital?	<input type="checkbox"/> Y <input type="checkbox"/> N	Attended admitting hospital for discharge samples and review?	<input type="checkbox"/> Y <input type="checkbox"/> N
Date last seen by research team <i>This may be after discharge and leaving hospital if the child absconds or leaves unexpectedly and is brought back within 7days by the research team</i>	___/___/_____ <i>D D / M M / Y Y Y Y</i>	Time seen by research team 24H clock	__:__:__
Date left hospital	___/___/_____ <i>D D / M M / Y Y Y Y</i>	Phone number for follow-up	<input type="checkbox"/> Y <input type="checkbox"/> N
Primary caregiver going to same household as child at discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N	Returning to the same household as admitted from?	<input type="checkbox"/> Y <input type="checkbox"/> N
Child discharged with biological parent?	<input type="checkbox"/> Y <input type="checkbox"/> N	Child discharged to care home?	<input type="checkbox"/> Y <input type="checkbox"/> N
Child / family planning travel or relocation?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, able to attend follow up?	<input type="checkbox"/> Y <input type="checkbox"/> N

Anthropometry					
Weight <i>to be taken using SECA scales for CHAIN study</i>	___ . ___ kg		Length <i>to be taken using SECA 416 infantometer provided for CHAIN study</i>	Measurer 1	___ . ___ cm
				Measurer 2	___ . ___ cm
MUAC <i>To be taken using MUAC tape for CHAIN study</i>	Measurer 1	___ . ___ cm	Head circumference <i>To be taken using CHAIN measuring tape</i>	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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Discharge observations:

to be done by research team at discharge examination. If the child has absconded or discharged unexpectedly, and does not return use most recent observations documented by research team or do observations at household visit or if child returns after absconding/ referral

Unknown, child discharged from other hospital after referral > 1 week ago

Temperature	____. ____ °C	If absconded date and time observations done	____/____/____ : ____ <i>D D / M M / Y Y Y Y</i>
Heart rate <i>To be counted for 1 min</i>	____/minute	Respiratory rate <i>To be counted for 1 min</i>	____/minute
SaO2 <i>To be measured from finger or toe using pulse oximeter</i>	____ % Leave blank if unrecordable or not measured	<input type="checkbox"/> Measured in oxygen <input type="checkbox"/> Measured in room air <input type="checkbox"/> Unrecordable <input type="checkbox"/> Not measured (if absconded)	

1. 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		



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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 (select any that apply)	<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 (select any that apply)	<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. (select any that apply)	<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		

DISCHARGE TREATMENT

ANTIBIOTICS AT DISCHARGE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes IV Antibiotics as Outpatient? (Select any that apply)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Gentamicin <input type="checkbox"/> Ceftriaxone
	<input type="checkbox"/> Co-amoxiclav	<input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Chloramphenicol
	<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Amikacin <input type="checkbox"/> Meropenem
	<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Vancomycin <input type="checkbox"/> Metronidazole
	<input type="checkbox"/> Other _____	
Oral Antibiotics (Select any that apply)	<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 <input type="checkbox"/> Nalidixic acid
	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Flucloxacillin <input type="checkbox"/> Other _____
Other Discharge Treatment (Select any that apply)	<input type="checkbox"/> Anti-TB therapy	<input type="checkbox"/> Zinc
	<input type="checkbox"/> Anti-retroviral therapy (new)	<input type="checkbox"/> Vitamin A
	<input type="checkbox"/> Anti-convulsant (new)	<input type="checkbox"/> Vitamin D
	<input type="checkbox"/> Diuretic (any)	<input type="checkbox"/> Multivitamin
	<input type="checkbox"/> Calcium	<input type="checkbox"/> Iron supplement



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<input type="checkbox"/> Folic acid <input type="checkbox"/> Antimalarial <input type="checkbox"/> Oral steroid (any) <input type="checkbox"/> None	<input type="checkbox"/> Salbutamol inhaler <input type="checkbox"/> Deworming <input type="checkbox"/> RUTF <input type="checkbox"/> Other
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Nutrition and Follow-up

Discharged to nutrition program?	<input type="checkbox"/> None	<input type="checkbox"/> Therapeutic	<input type="checkbox"/> Supplementary
Breastfeeding questions: ask ALL caregivers.			
Breastfeeding at discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is the child receiving anything apart from breast milk? (exclude medicine)	<input type="checkbox"/> Y <input type="checkbox"/> N
Any re-lactation input during admission	<input type="checkbox"/> Y <input type="checkbox"/> N	Any Breastfeeding Counselling during admission	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, was re-lactation successful?	<input type="checkbox"/> Y <input type="checkbox"/> N	Breastfeeding counselling follow up arranged?	<input type="checkbox"/> Y <input type="checkbox"/> N
Any Nutrition counselling during admission	<input type="checkbox"/> Y <input type="checkbox"/> N	Does mother/carer think it is achievable to exclusively breastfeed an infant to age 6 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
Does mother/carer feel breastfeeding alone is sufficient for her child?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is mother/ carer willing to participate in further qualitative research on attitudes to breast feeding?	<input type="checkbox"/> Y <input type="checkbox"/> N
Primary caregiver follow-up			
Has the mother/carer been referred for any treatment or follow-up?	<input type="checkbox"/> Y <input type="checkbox"/> N	Has the family been referred for any social support?	<input type="checkbox"/> Y <input type="checkbox"/> N

Discharge Diagnosis

Select all that apply

Respiratory	Infection	CNS
<input type="checkbox"/> LRTI/pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> URTI	<input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> Confirmed Malaria	<input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Epilepsy <input type="checkbox"/> LP confirmed meningitis



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<input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Otitis media <input type="checkbox"/> Asthma	<input type="checkbox"/> Extra pulmonary TB <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> UTI <input type="checkbox"/> HIV related illness <input type="checkbox"/> Measles <input type="checkbox"/> Varicella <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Confirmed enteric fever <input type="checkbox"/> Typhoid/paratyphoid with perforation <input type="checkbox"/> Febrile illness unspecified	<input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Developmental delay unspecified <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Confirmed diagnosis congenital syndrome: _____ Other confirmed diagnosis: <input type="checkbox"/> Other _____ _____
General		
<input type="checkbox"/> Anaemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Renal impairment <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Nephritis <input type="checkbox"/> Liver dysfunction <input type="checkbox"/> Congenital cardiac disease confirmed by echo		

GPS LOCATION OF HOUSEHOLD (This is entered into the Enrolment CRF on REDCap Database)	
<i>Tick + or - to indicate N/S and W/E</i>	
Latitude: <input type="checkbox"/> + <input type="checkbox"/> - _____ . _____ _____	
Longitude <input type="checkbox"/> + <input type="checkbox"/> - _____ . _____ _____	
<p>NOTE: GPS must be set to decimal degrees DDD.DDDDDD (not degrees, minutes and seconds).</p>	



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11. Discharge Sample Collection					
CBC taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Plain Blood (serum)	<input type="checkbox"/> Y	<input type="checkbox"/> N
PBMC sample taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Clinical chemistry taken	<input type="checkbox"/> Y	<input type="checkbox"/> N
EDTA 2ml blood taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood spot taken	<input type="checkbox"/> Y	<input type="checkbox"/> N
0.5ml EDTA sample taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Green top WBA sample taken	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blood gas taken (if available at site)	<input type="checkbox"/> Capillary <input type="checkbox"/> Venous				
Date Taken	Date taken _____ Time taken _____ : _____ <small> D D / M M / Y Y Y Y</small>				
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 before leaving? <input type="checkbox"/> Y <input type="checkbox"/> N	Date taken _____ : _____ <small> D D / M M / Y Y Y Y</small>		Time taken _____ : _____	

Blood Samples taken by (initials)	_____
Rectal Swabs taken by (initials)	_____
Home visit organised by (initials)	_____

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

