

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



RE-DISCHARGE CRF

To be completed at discharge following readmission

Discharge Details			
Date discharged by medical team:	___/___/_____ <i>D D/M M/Y Y Y Y</i>	Time discharged by medical team <i>24H clock</i>	__:__:__ <input type="checkbox"/> Unknown
Discharged against medical advice	<input type="checkbox"/> Y <input type="checkbox"/> N	Abscinded	<input type="checkbox"/> Y <input type="checkbox"/> N
Date last seen by research team	___/___/_____ <i>D D/M M/Y Y Y Y</i>	Time seen by research team <i>24H clock</i>	__:__:__
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

Discharge observations:			
<i>to be done by research team at discharge examination. If the child has absconded use most recent observations documented</i>			
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)



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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 (select one)	<input type="checkbox"/> Clear	<input type="checkbox"/> Needs active support	<input type="checkbox"/> Obstructed/Stridor
Breathing (select all that apply)	<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
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 (Select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Poorly	<input type="checkbox"/> Not drinking
	<input type="checkbox"/> Eager / Thirsty		
Abdomen (select any that apply)	<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	
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"/> 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"/> Maculopapular
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"/> Buttocks	<input type="checkbox"/> Arms	<input type="checkbox"/> Legs
			<input type="checkbox"/> Perineum



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Discharge Diagnosis		
Respiratory	Infection	CNS
<input type="checkbox"/> LRTI/pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> URTI <input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Otitis media <input type="checkbox"/> Asthma	<input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> Confirmed Malaria <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"/> Febrile convulsions <input type="checkbox"/> Epilepsy <input type="checkbox"/> LP confirmed meningitis <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: _____
General		Other confirmed diagnosis:
<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		<input type="checkbox"/> Other _____

How likely does the clinical team think this child is to die within 6 months? *Select one*

<input type="checkbox"/> Almost certainly not	<input type="checkbox"/> Very unlikely	<input type="checkbox"/> Quite unlikely	<input type="checkbox"/> Unsure	<input type="checkbox"/> Quite likely	<input type="checkbox"/> Very likely	<input type="checkbox"/> Almost certainly
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DISCHARGE TREATMENT			
ANTIBIOTICS AT DISCHARGE	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes IV Antibiotics as Outpatient? <i>Select any that apply</i>	<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 <i>Select any that apply</i>	<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 <i>Select any that apply</i>	<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	<input type="checkbox"/> Multivitamin	
	<input type="checkbox"/> Calcium	<input type="checkbox"/> Iron supplement	
	<input type="checkbox"/> Antimalarial	<input type="checkbox"/> Deworming	
	<input type="checkbox"/> None	<input type="checkbox"/> Other	

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

