

CHAIN Number [1][0][0][0][2][][][][]



The Childhood Acute Illness & Nutrition Network

Readmission to Hospital			
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 seen by research team	____/____/____ <i>D D / M M / Y Y Y Y</i>	TIME seen by research team	____:____ <i>24h Clock</i>

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

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"/> Other (<i>only one complaint, if not covered by above options</i>)	

Current History			
Length of current illness	If prolonged illness Number of days: ____ months		
Previously admitted to hospital. <i>Include other hospitals / health centres. Select 1</i>	<input type="checkbox"/> No	<input type="checkbox"/> <1 week ago	<input type="checkbox"/> 1week-1month ago <input type="checkbox"/> >1month ago
Any medication last 7 days. <i>Select all that apply</i>	<input type="checkbox"/> No medication	<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Antimalarial <input type="checkbox"/> Traditional/ Herbal/ Homeopathy
	<input type="checkbox"/> Deworming	<input type="checkbox"/> Yes, but unknown	<input type="checkbox"/> ORS <input type="checkbox"/> Paracetamol/ibuprofen
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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Anthropometry and Nutrition			
Weight <i>to be taken using SECA scales for CHAIN</i>	_____ . _____ kg	Length <i>to be taken using SECA 416 infantometer provided for CHAIN</i>	Measurer 1 _____ . _____ cm
			Measurer 2 _____ . _____ cm
MUAC <i>To be taken using MUAC tape for CHAIN</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 1 _____

Feeding			
Currently in outpatient nutrition program? <i>Select one.</i>	<input type="checkbox"/> Supplementary <i>(corn soy blend, RUSF, khichuri, halwa)</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 is the child taking anything else (exclude medicine)?	<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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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)	<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	<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 <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/ 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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TB Screening							
Known TB (on treatment)		Child has cough >14 days		Household contact has TB, or cough >14 days		Child has suspected extra- pulmonary TB	
Y	N	Y	N	Y	N	Y	N

Immediate Clinical Investigations						
Malaria RDT <i>circle result</i>	Positive		Negative		Not done	
Blood glucose	_____ . ____ mmol /L		Time glucose measured		____ : ____ <i>24h clock</i> <input type="checkbox"/> Unknown	
Urine Dipstick <i>(can be done at any time during admission)</i> <input type="checkbox"/> Not done <input type="checkbox"/> Bag <input type="checkbox"/> Clean catch	Protein + ++ +++ None	Nitrites Pos Neg	Leucocytes + ++ +++ None	Blood + ++ +++ None	Ketones + ++ +++ None	Glucose + ++ +++ None

Suspected Initial Diagnoses:		
<i>Clinical diagnosis should be based on examination and investigation findings. Tick the <u>three</u> most likely diagnoses.</i>		
Respiratory <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 General <input type="checkbox"/> Anaemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Thalassaemia <input type="checkbox"/> Renal impairment <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Nephritis <input type="checkbox"/> Liver dysfunction <input type="checkbox"/> Ileus <input type="checkbox"/> Congenital cardiac disease	Infection <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> 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"/> Febrile illness unspecified <input type="checkbox"/> Enteric fever	CNS <input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Epilepsy <input type="checkbox"/> Probable meningitis <input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Developmental delay <input type="checkbox"/> Cerebral palsy Other suspected diagnosis: <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Failed appetite test only

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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	
Date and time First antibiotics given	____ / ____ / _____ : ____:____ <i>24h clock</i>	
Intravenous Antibiotics Given? <input type="checkbox"/> Not given	<input type="checkbox"/> Benzylpenicillin <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 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 <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> <i>For IV fluid bolus, and IV fluids specify type and volume in ml, and duration</i>	<input type="checkbox"/> IV Fluid Bolus	<input type="checkbox"/> IV Maintenance Fluids
	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Warmth (heater, warmed fluids)
	<input type="checkbox"/> IV Glucose <input type="checkbox"/> Oral Glucose	<input type="checkbox"/> Commercial F75
	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Commercial F100
	<input type="checkbox"/> Phenobarbitone	<input type="checkbox"/> Locally prepared F75/ milk suji
	<input type="checkbox"/> Diazepam	<input type="checkbox"/> Local prepared F100 / milk suji 100
	<input type="checkbox"/> Paracetamol	<input type="checkbox"/> Expressed breast milk
	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Dilute F100
	<input type="checkbox"/> Antimalarial	<input type="checkbox"/> Other milk/ formula/ feed
	<input type="checkbox"/> ReSoMal	<input type="checkbox"/> Other
<input type="checkbox"/> ORS	_____	

Clinicians impression of risk	
<i>How likely does the clinical team think this child is to die during this admission? Select one</i>	
<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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Readmission investigations and Sample Collection

THESE MAY BE TAKEN AT ANY TIME DURING READMISSION

CBC taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Plain Blood (serum)	<input type="checkbox"/> Y <input type="checkbox"/> N	Date taken: ___/___/_____ <i>D D / M M / Y Y Y Y</i> Time taken ____:____
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			
EDTA 0.5ml blood taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood culture taken	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> Y AFTER ABX <input type="checkbox"/> N	
Heparinised for PBMCs (immunology sites only)	<input type="checkbox"/> Y <input type="checkbox"/> N			
Blood gas taken	<input type="checkbox"/> Capillary <input type="checkbox"/> Venous <input type="checkbox"/> N			
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"/> N <input type="checkbox"/> Y AFTER ABX			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			Time taken ____:____ <input type="checkbox"/> unknown

Chest x-ray indicated <i>(respiratory signs symptoms)</i>	<input type="checkbox"/> Yes, but too unwell	<input type="checkbox"/> Yes, done	<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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END