



Readmission to Hospital			
<b>DATE arrived at the hospital</b>	____/____/_____ <i>D D / M M / Y Y Y Y</i>	<b>TIME arrived at the hospital</b>	____:____ <i>24h Clock</i> <input type="checkbox"/> Arrival time unknown
<b>DATE seen by research team</b>	____/____/_____ <i>D D / M M / Y Y Y Y</i>	<b>TIME seen by research team</b>	____:____ <i>24h Clock</i>

Initial Observations			
<i>to be taken at time of examination by research team</i>			
<b>Axillary temperature</b>	____.____ °C	<b>Respiratory rate</b> <i>Count for 1 minute</i>	____/minute
<b>Heart rate</b> <i>Count for 1 minute</i>	____/minute		
<b>SaO2</b> <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

1. 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 >14 days	<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 checked="" type="checkbox"/> Neonatal jaundice	<input checked="" type="checkbox"/> Umbilical infection
<input type="checkbox"/> Other ( <i>only one complaint, if not covered by above options</i> )		



Anthropometry and Nutrition			
<b>Weight</b> <i>to be taken using SECA scales for CHAIN</i>	_____ . _____ kg	<b>Length</b> <i>to be taken using SECA 416 infantometer provided for CHAIN</i>	Measurer 1 _____ . _____ cm
			Measurer 2 _____ . _____ cm
<b>MUAC</b> <i>To be taken using MUAC tape for CHAIN</i>	Measurer 1 _____ . _____ cm	<b>Head circumference</b> <i>To be taken using CHAIN measuring tape</i>	Measurer 1 _____ . _____ cm
	Measurer 2 _____ . _____ cm		Measurer 2 _____ . _____ cm
<b>Oedema</b> <input type="checkbox"/> None <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++		<b>Initials</b>	Measurer 1 _____ Measurer 2 _____

1. Current Health	
<b>Previously admitted to hospital.</b> <i>Include other hospitals / health centres. Select 1</i>	<input type="checkbox"/> No <input type="checkbox"/> < 1 week ago <input type="checkbox"/> 1 weeks-1month ago <input type="checkbox"/> >1month ago
<b>Any medication last 7 days.</b> <i>Select all that apply</i>	<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
<b>Urine volume in last 24hrs?</b> <i>Select 1</i>	<input type="checkbox"/> Not passing urine <input type="checkbox"/> Less than normal <input type="checkbox"/> Normal or greater <input type="checkbox"/> Unknown

Feeding			
<b>Currently in outpatient nutrition program?</b> <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
<b>Has the child eaten these nutrition products in the last 3 days?</b>	<input type="checkbox"/> Supplementary	<input type="checkbox"/> Therapeutic	<input type="checkbox"/> None
<b>Currently Breastfeeding?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>If yes is the child taking anything else (exclude medicine)?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If NO breastfeeding at all, age stopped in months?</b> <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		



<b>Examination</b>	
<i>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</i>	
<b>Airway</b> <i>(select one)</i>	<input type="checkbox"/> Clear <input type="checkbox"/> Needs active support <input type="checkbox"/> Obstructed/Stridor
<b>Breathing</b> <i>(select all that apply)</i>	<input type="checkbox"/> <b>Normal – no concerns</b> , (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
<b>Circulation:</b> <b>Cap Refill</b> (select one)	<input type="checkbox"/> >3s <input type="checkbox"/> 2-3s <input type="checkbox"/> <2s
<b>Cold Peripheries</b> (select one)	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Warm peripheries
<b>Disability:</b> <b>Conscious level</b> (select one)	<input type="checkbox"/> <b>Alert</b> <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive
<b>Fontanelle</b> (select one)	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Not present
<b>Tone</b> (select one)	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Hypertonic <input type="checkbox"/> Hypotonic
<b>Posture</b> (select one)	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Decorticate <input type="checkbox"/> Decerebrate
<b>Activity</b> (select one)	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Irritable/Agitated <input type="checkbox"/> Lethargic
<b>Dehydration:</b> <b>Sunken eyes?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Skin pinch</b> (select one)	<input type="checkbox"/> >2 seconds <input type="checkbox"/> <2 seconds <input type="checkbox"/> Immediate
<b>Drinking/Breastfeeding)</b>	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Poorly <input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
<b>Abdomen</b> <i>(select any that apply)</i>	<input type="checkbox"/> <b>Normal – no concerns</b> <input type="checkbox"/> Distension <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Tenderness <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Other abdominal mass
<b>Signs of Rickets</b>	<input type="checkbox"/> <b>None</b> <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
<b>Jaundice</b>	<input type="checkbox"/> <b>Not jaundiced</b> <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++
<b>ENT/Oral/Eyes</b> <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
<b>Skin</b> <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
<b>Site of skin lesions.</b> <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



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	
<b>Blood glucose</b>	_____ . ____ mmol /L		<b>Time glucose measured</b>		____ : ____ 24h clock <input type="checkbox"/> Unknown	
<b>Urine Dipstick</b> <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

11. Suspected Initial Diagnoses:		
<i>Clinical diagnosis should be based on examination and investigation findings. Tick the <u>three most likely</u> diagnoses.</i>		
<b>Respiratory</b> <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 <b>General</b> <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 <input checked="" type="checkbox"/> Haemolytic disease newborn <input checked="" type="checkbox"/> Neonatal jaundice	<b>Infection</b> <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 <input checked="" type="checkbox"/> Infected umbilicus	<b>CNS</b> <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 <b>Other suspected diagnosis:</b> <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Failed appetite test only <input checked="" type="checkbox"/> Breast-feeding difficulty



11. Initial Treatment				
<b>Admitted to:</b> <i>select one</i>	<input type="checkbox"/> Admission to ward	<input type="checkbox"/> Admission to HDU	<input type="checkbox"/> Admission to ICU	
<b>Date and time First antibiotics given</b>	<input type="checkbox"/> Admission to neonatal unit ___ / ___ / ___ : ___			
<b>Intravenous Antibiotics Given?</b>	<input type="checkbox"/> Not given			
<input type="checkbox"/> Not given	<input type="checkbox"/> Benzylpenicillin <input type="checkbox"/> Co-amoxiclav/ Augmentin <input type="checkbox"/> Ampicillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Ceftazidime <input type="checkbox"/> Other _____	<input type="checkbox"/> Gentamicin <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Vancomycin <input type="checkbox"/> Pivmecillinam	<input type="checkbox"/> Ceftriaxone / Cefotaxime <input type="checkbox"/> Chloramphenicol <input type="checkbox"/> Meropenem / Imipenem <input type="checkbox"/> Metronidazole	
<b>Oral Antibiotics Given?</b>	<input type="checkbox"/> Not given			
<input type="checkbox"/> Not given	<input type="checkbox"/> Amoxicillin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Penicillin <input type="checkbox"/> Other _____	<input type="checkbox"/> Erythromycin <input type="checkbox"/> Metronidazole <input type="checkbox"/> Co-amoxiclav / Augmentin <input type="checkbox"/> Flucloxacillin	<input type="checkbox"/> Azithromycin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Nalidixic acid <input type="checkbox"/> Levofloxacin	
<b>Initial treatment given</b> <i>First 6 hours. Select any that apply.</i>	<input type="checkbox"/> IV Fluid Bolus <input type="checkbox"/> Oxygen <input type="checkbox"/> IV Glucose <input type="checkbox"/> Oral Glucose <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Phenobarbitone <input type="checkbox"/> Diazepam <input type="checkbox"/> Paracetamol <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Diclofenac <input type="checkbox"/> Salbutamol / atrovent / other bronchodilator <input type="checkbox"/> Prednisolone/ dexamethasone/ hydrocortisone <input type="checkbox"/> Adrenaline <input type="checkbox"/> Zinc <input type="checkbox"/> Folic acid <input type="checkbox"/> Antimalarial (any) <input type="checkbox"/> ReSoMal <input type="checkbox"/> ORS			<input type="checkbox"/> IV Maintenance Fluids <input type="checkbox"/> CPAP <input type="checkbox"/> Warmth (heater, warmed fluids) <input type="checkbox"/> Commercial F75 <input type="checkbox"/> Commercial F100 <input type="checkbox"/> Locally prepared F75/ milk suji <input type="checkbox"/> Local prepared F100 / milk suji 100 <input type="checkbox"/> Expressed breast milk <input type="checkbox"/> Dilute F100/ dilute milk or formula <input type="checkbox"/> Other milk/ formula/ feed <input type="checkbox"/> RUTF <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Multivitamin <input type="checkbox"/> Micronutrients <input type="checkbox"/> Vitamin A <input type="checkbox"/> Albendazole / deworming <input type="checkbox"/> Other _____

### Clinicians impression of risk

*How likely does the clinical team think this child is to die during this admission? Select one*



Readmission CRF V1.62

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

Almost certainly not   
  Very unlikely   
  Quite unlikely   
  Unsure   
  Quite likely   
  Very likely   
  Almost certainly

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

<b>Chest x-ray indicated</b> <i>(respiratory signs symptoms)</i>	<input type="checkbox"/> Yes, but too unwell	<input type="checkbox"/> Yes, done	<input type="checkbox"/> Not indicated
<b>Lumbar puncture indicated</b> <i>(signs of meningitis documented)</i>	<input type="checkbox"/> Yes, but too unwell	<input type="checkbox"/> Yes, done	<input type="checkbox"/> Not indicated
<b>Blood Samples taken by (initials)</b>	_____		
<b>Rectal Swabs taken by (initials)</b>	_____		

<b>CRF Completed by (Initials) – to be signed when complete.</b> <i>Do not sign if any fields are empty</i>	_____	Date	Time
		_____ / _____ / _____ <i>DD / MM / YYYY</i>	_____ : _____

END