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

To be used if child is referred to another hospital, or to a specialist department within the same hospital e.g. Oncology, Neurology, Nephrology, Cardiology

REFERRAL								
Date of referral:	__ __/__ __/__ __ __ __ *D D / M M / Y Y Y Y*			**Time of referral** 24H clock	__ __:__ __ Unknown			
Name of Referral hospital								
Reason for Referral *Select any that apply*								
☐Requires intubation and ventilation (PICU)	☐Blood transfusion	☐Specialist Radiology ☐ MRI ☐ CT ☐ USS	☐Renal assessment ☐Requires dialysis	☐Cardiology ☐ Echo only	☐Echo and surgery	☐ Surgery	☐ Neurology assessment	☐Oncology assessment for suspected malignancy
☐ Family choice / referral to private facility								
☐ Other (e.g. trauma or burns if readmitted)								

CHAIN research team able to review child at referral hospital?	Y	N	**If yes, is this the same team as at the admission hospital?**	Y N
If No is there a discharge letter?	Y	N	**If No record the outcome for the child from the referral hospital and arrange follow up visits. If Yes, complete further information below**	
If CHAIN research team are able to attend the referral hospital they should complete daily record and any samples that are indicated including those for clinical deterioration **If CHAIN team unable to attend use the discharge letter to complete the discharge form and contact the family to arrange home visit and follow up**				

Surgical Procedures (include chest drain)				
Date of surgery	__ __/__ __/__ __ __ __ *D D / M M / Y Y Y Y*			
Procedure done	☐ Laparotomy for suspected perforation ☐ Laparotomy for suspected obstruction ☐ Chest drain ☐ Endoscopy ☐ Other_____			
Required PICU/HDU after surgery?	Y	N	**Complications**	Y N

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Admission to PICU Complete ONLY if in PICU located at a different hospital, OR if intubated and ventilated or on inotropes at local PICU			
Date of admission to PICU	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y	Date of discharge from PICU	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y
Intubated and ventilated	Y N	Number of days ventilated	
Inotropes	Y N	Inotrope used	☐ Dopamine ☐ Dobutamine ☐ Adrenaline ☐ Noradrenaline ☐ Milrinone

Specialist radiology						
CT scan	Date	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y			☐ Unknown	
	☐Brain	☐Chest	☐Abdomen	☐Other _____	Normal?	Y N Don't know
USS scan	Date	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y			☐ Unknown	
	☐Abdomen	Other (if renal see below)			Normal?	Y N Don't know
MRI	Date	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y			☐ Unknown	
	Brain Y N	Other			Normal?	Y N Don't know

Cardiology				
Echo	Y N	If yes date	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y	
If yes diagnosis	☐ Normal ☐ AVSD ☐ Other	☐ VSD ☐ Aortic stenosis	☐ ASD ☐ Tetralogy of Fallot	☐ Persistent ductus ☐ Cardiomyopathy
Cardiac failure	Y N	Cyanosis	Y	N
Surgery planned/done?	Y N	If yes date	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y	
Medication?	Y N	☐ACE inhibitor ☐Digoxin	☐Furosemide ☐ Beta blocker	☐Spironolactone ☐Other

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Renal Assessment							
Renal Failure?	Y N	**Renal Ultrasound scan**	Y N	If yes date __ __/__ __/__ __ __ __ D D / M M / Y Y Y Y	☐ Normal	☐ Abnormal	
Biopsy	Y N	**If yes dates**	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown				
		Report available?	Y N	If yes _____			
Dialysis	Y N	If yes dates ☐ Haemodialysis ☐ Peritoneal Dialysis	From __ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐ Unknown	To __ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐ Unknown	☐ Ongoing		
Seen by nephrologist	Y N	**Follow up organised**	Y N	Date of follow up	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐ Unknown		
Medication?	Y N	☐ACE inhibitor	☐Furosemide	☐Spironolactone	☐ Prednisolone	☐Other	

Neurology Assessment					
EEG	Y N	If yes date __ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown	☐ Normal	☐ Abnormal	
Seen by specialist neurologist?	Y N	Follow up organised?	Y N	If yes Date of follow up	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐ Unknown
Diagnosis made	Y N	If yes	☐ Cerebral palsy ☐ Epilepsy ☐Hydrocephalus Other ☐ Brain abscess ☐Stroke / CVA ☐ Tumour		
Medication	Y N	☐Phenobarbitone ☐Sodium valproate ☐Baclofen ☐Diazepam ☐Phenytoin ☐Carbamazepine ☐ Other ☐ Topiramate ☐ Lamotrigine _____			

Oncology Assessment				
Seen by Oncologist	Y N	If yes date	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown	
Cancer diagnosed?	Y N	If yes, diagnosis		
Starting curative treatment?	Y N	If no, palliative?	Y	N

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Transfusion				
Blood available?	Y	N	Date of transfusion	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown
2nd Transfusion	Y	N	Date of transfusion	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown
3rd Transfusion	Y	N	Date of transfusion	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown
Platelet transfusion	Y	N	Date of transfusion	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown
Fresh frozen plasma / Cryoprecipitate	Y	N	Date of transfusion	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y ☐Unknown

Other			
Trauma	Y	N	
Head injury	Y	N	
Burns	Y	N	
Poisoning	Y	N	
Miscellaneous	Y	N	

Discharge from Referral Hospital			
Date of discharge from referral hospital	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y	If patient died date of death	__ __/__ __/__ __ __ __ D D / M M / Y Y Y Y
Inpatient verbal autopsy complete?	Y N	If no state why Complete study conclusion form.	☐Insufficient detail in discharge letter ☐Unable to contact family
Destination at discharge	☐ Home – same as pre-admission ☐ Home – different residence	☐ Home – different residence ☐ Transfer to other hospital	☐Return to enrolling hospital ☐ Unknown
Home visit by CHAIN team at discharge?	Y N	CHAIN Follow up arranged?	Y N

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