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Follow up at 45 days TO BE COMPLETED WITHIN 14 DAYS OF SCHEDULED APPT BY TELEPHONE IF PARTICIPANT UNABLE TO ATTEND. IF PARTICIPANT ATTENDS LATER, AMEND CRF			
DATE SEEN:	___/___/____ <i>D D / M M / Y Y Y Y</i>	TIME SEEN: 24H Clock	__:__:__
Informed consent reviewed with caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No	Caregiver gives consent for samples at this appointment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seen at:	<input type="checkbox"/> Hospital / clinic	<input type="checkbox"/> Seen in community	<input type="checkbox"/> Not seen
If not seen within 2 weeks of scheduled appointment	<input type="checkbox"/> Confirmed alive only e.g. telephoned to confirm vital status	DATE CONTACTED	___/___/____ <i>D D / M M / Y Y Y Y</i>
	<input type="checkbox"/> Confirmed dead Complete verbal autopsy and study conclusion	DATE CONTACTED	___/___/____ <i>D D / M M / Y Y Y Y</i>
Not seen within 2 weeks but willing to attend appointment in future	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE OF LAST TELEPHONE CALL	___/___/____
		<input type="checkbox"/> Unable to contact by telephone or home visit DATE OF HOME VISIT	If patient did not attend and could not be reached by telephone ___/___/____ <i>D D / M M / Y Y Y Y</i>

Anthropometry and Nutrition			
Weight to be taken using SECA scales for CHAIN	___ __ . ___ __ kg	Length to be taken using SECA 416 infantometer provided for CHAIN	Measurer 1 _____ . _____ cm
			Measurer 2 _____ . _____ cm
MUAC To be taken using MUAC tape for CHAIN	Measurer 1 _____ . _____ cm	Head circumference To be taken using CHAIN measuring tape	Measurer 1 _____ . _____ cm
	Measurer 2 _____ . _____ cm		Measurer 2 _____ . _____ cm



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Oedema	<input type="checkbox"/> None <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++	Initials	Measurer 1 ____	Measurer 2 ____ ____
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Current Health					
Child in usual state of health now?	Y	N	If No, length of current illness	Number of days: _____ _____	
What symptoms are present now? <i>Select up to 3:</i>					
<input type="checkbox"/> No symptoms, child is well <input type="checkbox"/> Vomiting <input type="checkbox"/> Fever / Hotness of body <input type="checkbox"/> Lethargy <input type="checkbox"/> Diarrhoea <14 days <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Convulsions <input type="checkbox"/> Diarrhoea >14 days <input type="checkbox"/> Cough<14 days <input type="checkbox"/> Altered consciousness <input type="checkbox"/> Blood in stool <input type="checkbox"/> Cough>14days <input type="checkbox"/> Not feeding <input type="checkbox"/> Poor feeding / weight loss <input type="checkbox"/> Body swelling/ oedema <input type="checkbox"/> Rash / skin lesion					
Medication last 7 days. <i>Circle any that apply</i>	<input type="checkbox"/> No medication	<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Antimalarial	<input type="checkbox"/> Deworming	<input type="checkbox"/> Multivitamin
	<input type="checkbox"/> Zinc	<input type="checkbox"/> Iron supplement	<input type="checkbox"/> Vitamin D/ Calcium	<input type="checkbox"/> Traditional / herbal / homeopathy	<input type="checkbox"/> Paracetamol/ Ibuprofen
	<input type="checkbox"/> ORS	<input type="checkbox"/> Antihistamine		<input type="checkbox"/> Yes, but unknown	

HOSPITAL ADMISSIONS			
Any admissions (e.g. overnight stay) to a hospital since discharge?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If Yes: Admission date (estimate)	Hospital Name	Length of stay (days)	Source of information



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____ / ____ / ____ <i>D D / M M / Y Y Y Y</i>			<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
____ / ____ / ____ <i>D D / M M / Y Y Y Y</i>			<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report

Outpatient Appointments		
Participant attended outpatient appointment since discharge?		
Nutrition follow-up only	Y	N
General paediatric appointment	Y	N
Cardiology appointment	Y	N
Neurology appointment	Y	N
HIV clinic	Y	N
TB clinic	Y	N
Sickle cell or thalassaemia clinic	Y	N
Outpatient blood transfusion	Y	N
Specialist Radiology	Y	N
Other specialist paediatric appointment	Y	N

Caregiver Appointments / Admissions		
<input type="checkbox"/> No outpatient appointment	<input type="checkbox"/> Not applicable – child in care	
Caregiver admitted to hospital since last Y appointment?		N
Psychiatry follow-up	Y	N
Antenatal care	Y	N
HIV clinic	Y	N
TB clinic	Y	N
Other	Y	N

Feeding



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Currently in outpatient nutrition program? <i>Select one. If not in feeding program circle 'none'</i>		<input type="checkbox"/> Supplementary <i>(corn soy blend, RUSF, khichuri, halwa etc)</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, taking other foods/fluids?	<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

Vaccinations – Ask carer or check book / card if available							
BCG scar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rotavirus	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
Measles	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	Pneumococcus	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown	DTP/Penta	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
			Polio	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown

TB Screening			
Known TB (on treatment)	Child has cough >14 days	Household contact has TB, or cough >14 days	Child has suspected extrapulmonary TB
Y N	Y N	Y N	Y N

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CHANGES TO CHILD'S SOCIAL SITUATION

Has the primary caregiver mostly lived in the same household as the child since last appointment?			<input type="checkbox"/> Y	<input type="checkbox"/> N		
Has the primary caregiver attended any medical appointments since last appointment?	<input type="checkbox"/> Y <input type="checkbox"/> N					
Primary caregiver HIV status since discharge <i>Select one</i>	<input type="checkbox"/> Known positive on treatment <input type="checkbox"/> Known positive not on treatment <input type="checkbox"/> Known treatment negative <input type="checkbox"/> Unknown treatment on					
Have there been changes to the child's social situation since discharge? <i>Select any that apply</i>						
Child moved to a different household	Y	N	Relocation from rural to urban setting <i>Select 'yes' even if this is temporary</i>	Y	N	
			Relocation from urban to rural setting <i>Select 'yes' even if this is temporary</i>	Y	N	
			Relocation to live with different caregiver <i>Select 'yes' even if this is temporary</i>	Y	N	
Mother sick	Y	N	Mother Died	Y	N	
Father sick	Y	N	Father Died	Y	N	
Other primary caregiver sick	Y	N	Other primary caregiver died	Y	N	N/A
Primary caregiver changed	Y	N	Child went into care home	Y	N	
Primary caregiver started employment / returned to school	Y	N	Person providing for the child has lost income	Y	N	
Primary caregiver divorced / separated from partner	Y	N	Primary caregiver in new relationship	Y	N	
Mother is pregnant	Y	N	Mother gave birth	Y	N	
Other primary caregiver pregnant?	Y	N	Other primary caregiver gave birth	Y	N	N/A
If primary caregiver has changed since discharge months, who was the child's previous primary caregiver? <i>Select one</i>						
<input type="checkbox"/> Biologic Mother	<input type="checkbox"/> Biologic Father	<input type="checkbox"/> Sibling ≥18 years old	<input type="checkbox"/> Sibling <18 years old			
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle/Cousin	<input type="checkbox"/> Other	<input type="checkbox"/> N/A			



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Child Dietary Diversity
<p>What does your child eat on a typical day? ASK THIS AS AN OPEN QUESTION AND SELECT ALL THAT THE CAREGIVER MENTIONS. DO NOT PRESENT THE CAREGIVER WITH THIS LIST. YOU MAY PROMPT THE CAREGIVER WITH OPEN QUESTIONS, e.g. WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST</p>
<input type="checkbox"/> Milk and Milk Products: Fresh/fermented milk, cheese, yogurt, or other milk products
<input type="checkbox"/> Breast milk
<input type="checkbox"/> Cereals and Cereal Products: Maize, rice, pasta, porridge, bread, biscuits, millet, sorghum, wheat and any other locally available grains
<input type="checkbox"/> Fish and Sea Foods: fresh or dried fish or shellfish
<input type="checkbox"/> Roots and Tubers: potatoes, sweet potatoes, yams, cassava, or foods made from roots or wild roots and tubers
<input type="checkbox"/> Vegetables: Cabbages, carrots, spinach, and any other locally available vegetables including wild vegetables
<input type="checkbox"/> Fruits: Oranges, bananas, mangoes, avocados, apples, grapes etc
<input type="checkbox"/> Meats and Poultry: Camel, beef, lamb, goat, rabbit, wild game, chicken or other birds, liver, kidney, heart, other organ meats or blood-based foods
<input type="checkbox"/> Eggs: Hen or other bird eggs
<input type="checkbox"/> Pulses / Legumes / Nuts and Seeds: Beans, peas, lentils, nuts, seeds or foods made from these
<input type="checkbox"/> Fats and Oils: Oil, fats, ghee, margarine or butter added to food or used for cooking
<input type="checkbox"/> Sugars / Honey and Commercial Juices: Sugar in tea, honey, sweetened soda, juices, chocolates, sweets or candies
<input type="checkbox"/> Miscellaneous: Spices, unsweetened beverages

Household Food Security	
<p>During the past 7 DAYS has ANY member of the household missed a meal due to food shortage?</p>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
<p>During the past 4 WEEKS</p>	
<p>Did you worry that your household would not have enough food?</p>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown



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Were any of your household unable to eat the kinds of food preferred because of a lack of resources?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household had to eat a limited variety of food due to lack of resources?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household eaten some foods that you really didn't want to eat because of lack of resources?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household eaten fewer meals in a day because there was not enough food?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Did household members go to sleep at night hungry because there was not enough food?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Did you or your household members go a whole day and night without eating anything because there was not enough food?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown

Plan day 90 visit	
Date of next visit _ _ / _ _ / _ _ _ _ <i>D D / M M / Y Y Y Y</i>	Any new contact details:

COMPLETE PHQ9 WITH PRIMARY CAREGIVER		
Primary caregiver present? (if no, complete PHQ9 at next follow up)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Is this the same primary caregiver who completed PHQ9 during admission?	<input type="checkbox"/> Y	<input type="checkbox"/> N



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D45 Core Cohort Investigations and Sample Collection			
CBC Taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Serum sample taken?	<input type="checkbox"/> Y <input type="checkbox"/> N
EDTA 2ml plasma blood taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood spot taken?	<input type="checkbox"/> Y <input type="checkbox"/> N
Unable to take blood samples, why?	<input type="checkbox"/> N/A <input type="checkbox"/> Difficult venepuncture <input type="checkbox"/> Child uncooperative <input type="checkbox"/> Parent refused <input type="checkbox"/> Other venepuncture within 12h <input type="checkbox"/> Readmitted – readmission samples		
Rectal swabs taken	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> N Number taken <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Y AFTER ABX Time taken ____: ____		
Stool sample taken	<input type="checkbox"/> Y <input type="checkbox"/> N Date taken: ____/____/____ D D / M M / Y Y Y Y Time taken ____: ____ <input type="checkbox"/> Unknown		

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	Time
	_____	____/____/____ D D / M M / Y Y Y Y	____: ____