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

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:	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*	TIME SEEN: 24H Clock	__ __: __ __
Informed consent reviewed with caregiver	☐ Yes ☐ No		
Seen at:	☐ Hospital / clinic	☐ Seen in community	☐ Not seen
If not seen within 2 weeks of scheduled appointment	☐ Confirmed alive only e.g. telephoned to confirm vital status	DATE CONTACTED	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*
	☐ Confirmed dead Complete verbal autopsy and study conclusion	DATE CONTACTED	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*
Not seen within 2 weeks but willing to attend appointment in future ☐ Yes ☐ No	☐ Unable to contact by telephone or home visit	DATE OF LAST TELEPHONE CALL DATE OF HOME VISIT If patient did not attend and could not be reached by telephone	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y* __ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*

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 Measurer 2 ____ ____ . ____ cm	**Head circumference** *To be taken using CHAIN measuring tape*	Measurer 1 ____ ____. _____cm Measurer 2 ____ ____. _____cm
Oedema	☐ None ☐ + ☐ ++ ☐ +++	**Initials**	Measurer 1 ___ ___ __ Measurer 2 ___ ___ __

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

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?
Select up to 3:

☐**No symptoms, child is well**

☐Vomiting	☐ Fever / Hotness of body	☐ Lethargy
☐Diarrhoea <14 days	☐ Difficulty breathing	☐ Convulsions
☐Diarrhoea >14 days	☐ Cough<14 days	☐ Altered consciousness
☐Blood in stool	☐ Cough>14days	☐ Not feeding
☐ Poor feeding / weight loss	☐ Body swelling/ oedema	☐Rash / skin lesion

Medication last 7 days. *Circle any that apply*	☐ No medication	☐·Antibiotic	☐ Antimalarial	☐Deworming	☐ Multivitamin
	☐ Zinc	☐Iron supplement	☐ Vitamin D/ Calcium	☐ Traditional / herbal / homeopathy	☐ Paracetamol/ Ibuprofen
	☐ ORS	☐ Antihistamine		☐ Yes, but unknown	

HOSPITAL ADMISSIONS

Any admissions (e.g. overnight stay) to a hospital since discharge?			☐Yes ☐ No ☐ Unknown
If Yes: **Admission date (estimate)**	**Hospital Name**	**Length of stay (days)**	**Source of information**
__ __/ __ __/ __ __ __ __ *D D / M M / Y Y Y Y*		__ __	☐Hospital letter or medical file ☐Parent/carer report

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

__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*		__ __	☐ Hospital letter or medical file ☐ 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		
☐ No outpatient appointment	☐ 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

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

Feeding			
Currently in outpatient nutrition program? *Select one. If not in feeding program circle 'none'*	☐ Supplementary *(corn soy blend, RUSF, khichuri, halwa etc)*	☐ Therapeutic *(RUTF, Plumpy-nut)*	☐ None
Has the child eaten these nutrition products in the last 3 days?	☐ Supplementary	☐ Therapeutic	☐ None
Currently Breastfeeding? ☐ Y ☐ N	**If yes, taking other foods/fluids?**	☐ Y ☐ N	
If NO breastfeeding at all, age stopped (in months)? *Select one*	☐ 0-3m ☐ 4-6m ☐ 7-12m	☐ >12m	☐ Unknown

Vaccinations – *Ask carer or check book / card if available*							
BCG scar	☐ Yes ☐ No	**Rotavirus**	☐ Book	☐ Self report	☐ Not received	**Doses received:** 3 2 1	☐ Unknown
Measles	☐ Book ☐ Self report ☐ Not received ☐ Unknown	**Pneumococcus**	☐ Book	☐ Self report	☐ Not received	**Doses received:** 3 2 1	☐ Unknown
		DTP/Penta	☐ Book	☐ Self report	☐ Not received	**Doses received:** 3 2 1	☐ Unknown
		Polio	☐ Book	☐ Self report	☐ Not received	☐ **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

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

Inform caregiver there will be samples taken at next visit.

Plan day 90 visit	
Date of next visit __ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y*	Any new contact details: Explained to parent that samples will be collected at next visit ☐ 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 __ __:__ __