CHAIN Number [5][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	__ __ : __ __
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	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*
		DATE OF HOME VISIT If patient did not attend and could not be reached by telephone	__ __ / __ __ / __ __ __ __ *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

CHAIN Number [5][0] [0][0][1] [ ][ ][ ]

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

Oedema	☐ None ☐ + ☐ ++ ☐ +++	**Initials**	Measurer 1 ___ ___ __ Measurer 2 ___ ___ __

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.	☐ No medication	☐·Antibiotic	☐ Antimalarial	☐Deworming	☐ Multivitamin

CHAIN Number [5][0] [0][0][1] [ ][ ][ ]

Circle any that apply	☐ 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
__ __/__ __/__ __ __ __ *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

CHAIN Number [5][0] [0][0][1] [ ][ ][ ]

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

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

CHAIN Number [5][0] [0][0][1] [ ][ ][ ]

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**	☐ Self ☐ Book report ☐ Not received	**Doses** 3 2 1 **received:** ☐ Unknown
Measles	☐ Book ☐ Self report ☐ Not received ☐ Unknown	**Pneumococcus**	☐ Self ☐ Book report ☐ Not received	**Doses** 3 2 1 **received:** ☐ Unknown
		DTP/Penta	☐ Self ☐ Book report ☐ Not received	**Doses** 3 2 1 **received:** ☐ Unknown
		Polio	☐ Self ☐ Book report ☐ Not received	☐ **Unknown**

TB Screening

CHAIN Number [5][0] [0][0][1] [ ][ ][ ]

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

Plan day 180 Follow Up Date

__ __/__ __/__ __ __ __

D D / M M / Y Y Y

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 ___ ___:___ ___