



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

<b>Follow up at 90 days</b> 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	____:____
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    ____/____/_____ <span style="margin-left: 150px;"><i>D D / M M / Y Y Y Y</i></span>		
	<input type="checkbox"/> Confirmed dead Complete verbal autopsy and study    DATE CONTACTED    ____/____/_____ conclusion <span style="float: right;"><i>D D / M M / Y Y Y Y</i></span>		
Not seen within 2 weeks but willing to attend appointment in future	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Unable to contact by telephone or home visit		
		DATE OF LAST TELEPHONE CALL	____/____/_____ <span style="margin-left: 100px;"><i>D D / M M / Y Y Y Y</i></span>
		DATE OF HOME VISIT If patient did not attend	____/____/_____ <span style="margin-left: 100px;"><i>D D / M M / Y Y Y Y</i></span>
		and could not be reached by telephone	

<b>Anthropometry and Nutrition</b>			
<b>Weight</b> to be taken using SECA scales for CHAIN	____ . ____ kg	<b>Length</b> to be taken using SECA 416 infantometer provided for CHAIN	Measurer 1 _____ . ____ cm
			Measurer 2 _____ . ____ cm



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

<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 _____
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Current Health				
<b>Child in usual state of health now?</b>	Y      N	<b>If No, length of current illness</b>	Number of days: _____ _____	
<b>What symptoms are present now?</b> <i>Select up to 3:</i>				
<input type="checkbox"/> <b>No symptoms, child is well</b>				
<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 >14 days	<input type="checkbox"/> Not feeding		
<input type="checkbox"/> Poor feeding / weight loss	<input type="checkbox"/> Body swelling/ oedema	<input type="checkbox"/> Rash / skin lesion		
<b>Medication last 7 days.</b>	<input type="checkbox"/> No medication	<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Antimalarial	<input type="checkbox"/> Deworming
				<input type="checkbox"/> Multivitamin



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

Circle any that apply	<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

____ / ____ / ____ <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



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		
<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			
<b>Currently in outpatient nutrition program?</b> <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



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

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

<b>CRF Completed by (Initials) – to be signed when complete.</b> <i>Do not sign if any fields are empty</i>	_____	Date	Time
	_____	___/___/_____	____:____
		<i>D D / M M / Y Y Y Y</i>	