



**DISCHARGE CRF**

**Discharge Details**

<b>Date discharged by medical team:</b>	___/___/_____ <i>D D / M M / Y Y Y Y</i>	<b>Time discharged by medical team</b> 24H clock	___:___ <input type="checkbox"/> Unknown
<b>Discharged against medical advice</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Absconded</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Discharged early because of e.g. staff strike, hospital closure</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Discharged unexpectedly, returned for review</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Discharged from referral hospital?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Attended admitting hospital for discharge samples and review?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Date last seen by research team</b> <i>This may be after discharge and leaving hospital if the child absconds or leaves unexpectedly and is brought back within 7 days by the research team</i>	___/___/_____ <i>D D / M M / Y Y Y Y</i>	<b>Time seen by research team</b> 24H clock	___:___
<b>Date left hospital</b>	___/___/_____ <i>D D / M M / Y Y Y Y</i>	<b>Phone number for follow-up</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Primary caregiver going to same household as child at discharge?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Returning to the same household as admitted from?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Child discharged with biological parent?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Child discharged to care home?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Child / family planning travel or relocation?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>If yes, able to attend follow up?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Research team will accompany child home?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>If no, date when home visit arranged</b>	___/___/_____ <i>D D / M M / Y Y Y Y</i>

**Anthropometry**

<b>Weight</b> <i>to be taken using SECA scales for CHAIN study</i>	___ . ___ kg		<b>Length</b> <i>to be taken using SECA 416 infantometer provided for CHAIN study</i>	Measurer 1	___ . ___ cm
				Measurer 2	___ . ___ cm
<b>MUAC</b> <i>To be taken using MUAC tape for CHAIN study</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: _____





**Discharge observations:**

*to be done by research team at discharge examination. If the child has absconded or discharged unexpectedly, and does not return use most recent observations documented by research team or do observations at household visit or if child returns after absconding/ referral*

Unknown, child discharged from other hospital after referral > 1 week ago

<b>Temperature</b>	_____ . _____ °C	<b>If absconded date and time observations done</b>	___/___/____-__-__ :__-__ <i>D D / M M / Y Y Y Y</i>
<b>Heart rate</b> <i>To be counted for 1 min</i>	_____/minute	<b>Respiratory rate</b> <i>To be counted for 1 min</i>	_____/minute
<b>SaO2</b> <i>To be measured from finger or toe using pulse oximeter</i>	_____% Leave blank if unrecordable or not measured	<input type="checkbox"/> Measured in oxygen	<input type="checkbox"/> Measured in room air <input type="checkbox"/> Unrecordable <input type="checkbox"/> Not measured (if absconded)





<b>Examination</b>	
<i>Examination should be performed by CHAIN study clinician trained in clinical examination of children, and able to formulate a diagnosis based on clinical history and findings. Refer to Clinical Examination SOP</i>	
<b>Airway</b> <i>(select one)</i>	<input type="checkbox"/> Clear <input type="checkbox"/> Needs active support <input type="checkbox"/> Obstructed/Stridor
<b>Breathing</b> <i>(select all that apply)</i>	<input type="checkbox"/> <b>Normal – no concerns</b> , (move to circulation) <input type="checkbox"/> Central cyanosis <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Reduced air-entry <input type="checkbox"/> Wheeze <input type="checkbox"/> Acidotic Breathing <input type="checkbox"/> Grunting <input type="checkbox"/> Lower chest wall indrawing <input type="checkbox"/> Crackles <input type="checkbox"/> Dull to percussion <input type="checkbox"/> Head nodding
<b>Circulation:</b>	
<b>Cap Refill</b> (select one)	<input type="checkbox"/> >3s <input type="checkbox"/> 2-3s <input type="checkbox"/> <2s
<b>Cold Peripheries</b> (select one)	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Warm peripheries
<b>Disability:</b>	
<b>Conscious level</b> (select one)	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive
<b>Fontanelle</b> (select one)	<input type="checkbox"/> Normal <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Not present
<b>Tone</b> (select one)	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonic <input type="checkbox"/> Hypotonic
<b>Posture</b> (select one)	<input type="checkbox"/> Normal <input type="checkbox"/> Decorticate <input type="checkbox"/> Decerebrate
<b>Activity</b> (select one)	<input type="checkbox"/> Normal <input type="checkbox"/> Irritable/Agitated <input type="checkbox"/> Lethargic
<b>Dehydration:</b>	
<b>Sunken eyes?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Skin pinch</b> (select one)	<input type="checkbox"/> >2 seconds <input type="checkbox"/> <2 seconds <input type="checkbox"/> Immediate
<b>Drinking/Breastfeeding</b> <i>(Select one)</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Poorly <input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
<b>Abdomen</b> <i>(select any that apply)</i>	<input type="checkbox"/> Normal – no concerns <input type="checkbox"/> Distension <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Tenderness <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Other abdominal mass
<b>Signs of Rickets</b>	<input type="checkbox"/> None <input type="checkbox"/> Wrist widening <input type="checkbox"/> Rachitic rosary <input type="checkbox"/> Swollen knees <input type="checkbox"/> Bow legs <input type="checkbox"/> Frontal bossing
<b>Jaundice</b> (Select one)	<input type="checkbox"/> Not jaundiced <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++
<b>ENT/Oral/Eyes</b> <i>(select any that apply)</i>	<input type="checkbox"/> Mouth Normal <input type="checkbox"/> Ears Normal <input type="checkbox"/> Eyes Normal <input type="checkbox"/> Oral ulceration <input type="checkbox"/> Pus from ear <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Oral candidiasis <input type="checkbox"/> Tender swelling behind ear (mastoiditis) <input type="checkbox"/> Eye discharge <input type="checkbox"/> Stomatitis <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Visual impairment
<b>Skin</b> <i>(select any that apply)</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Depigmentation <input type="checkbox"/> Broken skin <input type="checkbox"/> Dermatitis <input type="checkbox"/> 'Flaky paint' <input type="checkbox"/> Cellulitis <input type="checkbox"/> Impetigo <input type="checkbox"/> Pustules <input type="checkbox"/> Vesicles <input type="checkbox"/> Desquamation <input type="checkbox"/> Macular or papular
<b>Site of skin lesions.</b> <i>(select any that apply)</i>	<input type="checkbox"/> Not applicable (No rash) <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs <input type="checkbox"/> Palms / soles <input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum





**Discharge Diagnosis – what was the child treated for in hospital?**

*Select all that apply*

Respiratory	Infection	CNS
<input type="checkbox"/> LRTI/pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> URTI <input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Otitis media <input type="checkbox"/> Asthma	<input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> Confirmed Malaria <input type="checkbox"/> Extra pulmonary TB <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> UTI <input type="checkbox"/> HIV related illness <input type="checkbox"/> Measles <input type="checkbox"/> Varicella <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Confirmed enteric fever <input type="checkbox"/> Typhoid/paratyphoid with perforation <input type="checkbox"/> Febrile illness unspecified	<input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Epilepsy <input type="checkbox"/> LP confirmed meningitis <input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Developmental delay unspecified <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Confirmed diagnosis congenital syndrome: _____
General		Other confirmed diagnosis:
<input type="checkbox"/> Anaemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Renal impairment <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Nephritis <input type="checkbox"/> Liver dysfunction <input type="checkbox"/> Congenital cardiac disease confirmed by echo		<input type="checkbox"/> Other _____

**How likely does the clinical team think this child is to die within 6 months?** *Select one*

<input type="checkbox"/> Almost certainly not	<input type="checkbox"/> Very unlikely	<input type="checkbox"/> Quite unlikely	<input type="checkbox"/> Unsure	<input type="checkbox"/> Quite likely	<input type="checkbox"/> Very likely	<input type="checkbox"/> Almost certainly
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## DISCHARGE TREATMENT

ANTIBIOTICS AT DISCHARGE	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>If yes IV Antibiotics as Outpatient?</b> <i>Select any that apply</i>	<input type="checkbox"/> Penicillin <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Ampicillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other _____	<input type="checkbox"/> Gentamicin <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Vancomycin	<input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Chloramphenicol <input type="checkbox"/> Meropenem <input type="checkbox"/> Metronidazole
<b>Oral Antibiotics</b> <i>Select any that apply</i>	<input type="checkbox"/> Amoxicillin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Penicillin	<input type="checkbox"/> Erythromycin <input type="checkbox"/> Metronidazole <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Flucloxacillin	<input type="checkbox"/> Azithromycin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Nalidixic acid <input type="checkbox"/> Other _____
<b>Other Discharge Treatment</b> <i>Select any that apply</i>	<input type="checkbox"/> Anti-TB therapy <input type="checkbox"/> Anti-retroviral therapy (new) <input type="checkbox"/> Anti-convulsant (new) <input type="checkbox"/> Diuretic (any) <input type="checkbox"/> Calcium <input type="checkbox"/> Folic acid <input type="checkbox"/> Antimalarial <input type="checkbox"/> Oral steroid (any) <input type="checkbox"/> None	<input type="checkbox"/> Zinc <input type="checkbox"/> Vitamin A <input type="checkbox"/> Vitamin D <input type="checkbox"/> Multivitamin <input type="checkbox"/> Iron supplement <input type="checkbox"/> Salbutamol inhaler <input type="checkbox"/> Deworming <input type="checkbox"/> RUTF <input type="checkbox"/> Other	





### Nutrition and Follow-up

<b>Discharged to nutrition program?</b>	<input type="checkbox"/> None	<input type="checkbox"/> Therapeutic	<input type="checkbox"/> Supplementary
<b>Breastfeeding questions: ask ALL caregivers.</b>			
<b>Breastfeeding at discharge?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Is the child receiving anything apart from breast milk? (exclude medicine)</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Any re-lactation input during admission</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Any Breastfeeding Counselling during admission</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If yes, was re-lactation successful?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Breastfeeding counselling follow up arranged?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Any Nutrition counselling during admission</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Does mother/carer think it is achievable to exclusively breastfeed an infant to age 6 months?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Does mother/carer feel breastfeeding alone is sufficient for her child?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Is mother/ carer willing to participate in further qualitative research on attitudes to breast feeding?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Primary caregiver follow-up</b>			
<b>Has the mother/carer been referred for any treatment or follow-up?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Has the family been referred for any social support?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N

### Discharge Core Cohort Investigations and Sample Collection

*If the child absconded or discharged unexpectedly and then returns these may be taken after discharge*

*If the child is discharged <=12h after after previous blood sample do not take discharge blood samples.*

*Discharge rectal swabs should always be taken unless parent refuses*

<b>CBC taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Plain Blood (serum)</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Date taken:</b>
<b>Clinical chemistry taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>EDTA 0.5ml blood taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	___/___/___ <i>D D/M M/ Y Y Y Y</i>
<b>EDTA 2ml blood taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Blood spot taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	____:____ Time taken
<b>Unable to take blood samples, why?</b>	<input type="checkbox"/> Difficult venepuncture <input type="checkbox"/> Child uncooperative <input type="checkbox"/> Discharge within 12h of previous blood sample <input type="checkbox"/> Absconded / unexpected discharge > 1 week ago <input type="checkbox"/> Parent refused <input type="checkbox"/> Discharged from referral hospital >1w ago			
<b>Rectal swabs taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Number taken</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Refused		Time taken ____:____ 24h clock
<b>Stool sample taken when child recovering?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N			





<b>Blood Samples taken by (initials)</b>	_____
<b>Rectal Swabs taken by (initials)</b>	_____
<b>Home visit organised by (initials)</b>	_____

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