

CHAIN Number  
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**RE-DISCHARGE CRF**

To be completed at discharge following readmission

Discharge Details			
Date discharged by medical team:	___/___/_____ <i>D D/M M/Y Y Y Y</i>	Time discharged by medical team <i>24H clock</i>	___:___ <input type="checkbox"/> Unknown
Discharged against medical advice	<input type="checkbox"/> Y <input type="checkbox"/> N	Absconded	<input type="checkbox"/> Y <input type="checkbox"/> N
Date last seen by research team	___/___/_____ <i>D D/M M/Y Y Y Y</i>	Time seen by research team <i>24H clock</i>	___:___
Date left hospital	___/___/_____ <i>D D/M M/Y Y Y Y</i>	Phone number for follow-up	<input type="checkbox"/> Y <input type="checkbox"/> N
Primary caregiver going to same household as child at discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N	Returning to the same household as admitted from?	<input type="checkbox"/> Y <input type="checkbox"/> N
Child discharged with biological parent?	<input type="checkbox"/> Y <input type="checkbox"/> N	Child discharged to care home?	<input type="checkbox"/> Y <input type="checkbox"/> N
Child / family planning travel or relocation?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, able to attend follow up?	<input type="checkbox"/> Y <input type="checkbox"/> N

Discharge observations:			
<i>to be done by research team at discharge examination. If the child has absconded use most recent observations documented</i>			
Temperature	____.____ °C	If absconded date and time observations done	___/___/_____ <i>D D/M M/Y Y Y Y</i> ___:___
Heart rate <i>To be counted for 1 min</i>	_____/minute	Respiratory rate <i>To be counted for 1 min</i>	_____/minute
SaO2 <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)	



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### Examination

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

<b>Airway</b> (select one)	<input type="checkbox"/> Clear	<input type="checkbox"/> Needs active support	<input type="checkbox"/> Obstructed/Stridor
<b>Breathing</b> (select all that apply)	<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		
<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"/> <b>Alert</b>	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive
<b>Fontanelle</b> (select one)	<input type="checkbox"/> <b>Normal</b>	<input type="checkbox"/> Bulging	<input type="checkbox"/> Sunken <input type="checkbox"/> Not present
<b>Tone</b> (select one)	<input type="checkbox"/> <b>Normal</b>	<input type="checkbox"/> Hypertonic	<input type="checkbox"/> Hypotonic
<b>Posture</b> (select one)	<input type="checkbox"/> <b>Normal</b>	<input type="checkbox"/> Decorticate	<input type="checkbox"/> Decerebrate
<b>Activity</b> (select one)	<input type="checkbox"/> <b>Normal</b>	<input type="checkbox"/> Irritable/Agitated	<input type="checkbox"/> Lethargic
<b>Dehydration:</b> <b>Sunken eyes? Skin pinch</b> (select one)	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> >2 seconds	<input type="checkbox"/> <2 seconds	<input type="checkbox"/> Immediate
<b>Drinking/Breastfeeding</b> (Select one)	<input type="checkbox"/> <b>Normal</b>	<input type="checkbox"/> Poorly	<input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
<b>Abdomen</b> (select any that apply)	<input type="checkbox"/> <b>Normal – no concerns</b> <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"/> <b>None</b> <input type="checkbox"/> Wrist widening <input type="checkbox"/> Rachitic rosary <input type="checkbox"/> Swollen knees <input type="checkbox"/> Bow legs		
<b>Jaundice</b> (Select one)	<input type="checkbox"/> <b>Not jaundiced</b>	<input type="checkbox"/> +	<input type="checkbox"/> ++ <input type="checkbox"/> +++
<b>ENT/Oral/Eyes</b> (select any that apply)	<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		



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<b>Skin</b> <i>(select any that apply)</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Depigmentation
	<input type="checkbox"/> Excoriation <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"/> Maculopapular	
<b>Site of skin lesions.</b> <i>(select any that apply)</i>	<input type="checkbox"/> Not applicable <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs
(No rash)	<input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum

Discharge Diagnosis		
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: _____
<b>General</b>		<b>Other confirmed diagnosis:</b>
<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*



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Almost  Very  Quite  Unsure  Quite  Very likely  Almost certainly not unlikely unlikely likely certainly

**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"/> Gentamicin	<input type="checkbox"/> Ceftriaxone
	<input type="checkbox"/> Co-amoxiclav	<input type="checkbox"/> Flu/Cloxacillin	<input type="checkbox"/> Chloramphenicol
	<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Amikacin	<input type="checkbox"/> Meropenem
	<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Vancomycin	<input type="checkbox"/> Metronidazole
	<input type="checkbox"/> Other _____		
<b>Oral Antibiotics</b> <i>Select any that apply</i>	<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Azithromycin
	<input type="checkbox"/> Co-trimoxazole	<input type="checkbox"/> Metronidazole	<input type="checkbox"/> Ciprofloxacin
	<input type="checkbox"/> Cefalexin / cefaclor	<input type="checkbox"/> Co-amoxiclav	<input type="checkbox"/> Nalidixic acid
	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Flucloxacillin	<input type="checkbox"/> Other _____
<b>Other Discharge Treatment</b> <i>Select any that apply</i>	<input type="checkbox"/> Anti-TB therapy	<input type="checkbox"/> Zinc	
	<input type="checkbox"/> Anti-retroviral therapy (new)	<input type="checkbox"/> Vitamin A	
	<input type="checkbox"/> Anti-convulsant (new)	<input type="checkbox"/> Vitamin D	
	<input type="checkbox"/> Diuretic	<input type="checkbox"/> Multivitamin	
	<input type="checkbox"/> Calcium	<input type="checkbox"/> Iron supplement	
	<input type="checkbox"/> Antimalarial	<input type="checkbox"/> Deworming	
	<input type="checkbox"/> None	<input type="checkbox"/> Other	

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



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