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Readmission to Hospital			
<b>DATE arrived at the hospital</b>	___/___/_____ <i>D D / M M / Y Y Y Y</i>	<b>TIME arrived at the hospital</b>	___:___ <i>24h Clock</i> <input type="checkbox"/> Arrival time unknown
<b>DATE seen by research team</b>	___/___/_____ <i>D D / M M / Y Y Y Y</i>	<b>TIME seen by research team</b>	___:___ <i>24h Clock</i>

Initial Observations			
<i>to be taken at time of examination by research team</i>			
<b>Axillary temperature</b>	____.____ °C	<b>Respiratory rate</b> <i>Count for 1 minute</i>	____/minute
<b>Heart rate</b> <i>Count for 1 minute</i>	____/minute		
<b>SaO2</b> <i>To be taken from finger or toe using pulse oximeter</i>	____ % <input type="checkbox"/> Measured in unrecordable <input type="checkbox"/> Measured in Oxygen Room Air <input type="checkbox"/> Unrecordable <i>Leave blank if unrecordable</i>		

1. Presenting Complaints	
<input type="checkbox"/> Fever / Hotness of body	<input type="checkbox"/> Vomiting <input type="checkbox"/> Lethargy
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Diarrhoea <14 days <input type="checkbox"/> Convulsions
<input type="checkbox"/> Cough<14 days	<input type="checkbox"/> Diarrhoea >14 days <input type="checkbox"/> Altered consciousness
<input type="checkbox"/> Cough>14days	<input type="checkbox"/> Blood in stool <input type="checkbox"/> Not feeding
<input type="checkbox"/> Poor feeding/ Weight loss	<input type="checkbox"/> Developmental delay <input type="checkbox"/> Body swelling / limb swelling/ Oedema
<input type="checkbox"/> Rash/ skin lesion	<input checked="" type="checkbox"/> Neonatal jaundice <input checked="" type="checkbox"/> Umbilical infection
<input type="checkbox"/> Other ( <i>only one complaint, if not covered by above options</i> )	

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



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<i>To be taken using MUAC tape for CHAIN</i>	Measurer 2 _____ . _____ cm	<i>To be taken using CHAIN measuring tape</i>	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 1 _____

1. Current Health			
<b>Previously admitted to hospital.</b> <i>Include other hospitals / health centres. Select 1</i>	<input type="checkbox"/> No	<input type="checkbox"/> < 1 week ago	<input type="checkbox"/> 1 weeks-1month ago <input type="checkbox"/> >1month ago
<b>Any medication last 7 days.</b> <i>Select all that apply</i>	<input type="checkbox"/> No medication	<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Antimalarial
	<input type="checkbox"/> Deworming	<input type="checkbox"/> Vitamin	<input type="checkbox"/> Paracetamol or Ibupr
	<input type="checkbox"/> Yes, but unknown	<input type="checkbox"/> Other	<input type="checkbox"/> Traditional ofen
<b>Urine volume in last 24hrs?</b> <i>Select 1</i>	<input type="checkbox"/> Not passing urine	<input type="checkbox"/> Less than normal	<input type="checkbox"/> Normal or greater <input type="checkbox"/> Unknown

Feeding			
<b>Currently in outpatient nutrition program?</b> <i>Select one.</i>	<input type="checkbox"/> Supplementary <i>(corn soy blend, RUSF, khichuri, halwa)</i>	<input type="checkbox"/> Therapeutic <i>(RUTF, Plumpy-nut)</i>	<input type="checkbox"/> None
<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 is the child taking anything else (exclude medicine)?</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

Examination	
<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



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<p><b>Breathing</b> <i>(select all that apply)</i></p>	<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
<p><b>Circulation:</b> <b>Cap Refill</b> (select one)</p>	<input type="checkbox"/> >3s <input type="checkbox"/> 2-3s <input type="checkbox"/> <2s
<p><b>Cold Peripheries</b>(select one)</p>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Warm peripheries
<p><b>Disability:</b> <b>Conscious level</b>(select one)</p>	<input type="checkbox"/> <b>Alert</b> <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive
<p><b>Fontanelle</b>(select one)</p>	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Not present
<p><b>Tone</b>(select one)</p>	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Hypertonic <input type="checkbox"/> Hypotonic
<p><b>Posture</b>(select one)</p>	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Decorticate <input type="checkbox"/> Decerebrate
<p><b>Activity</b>(select one)</p>	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Irritable/Agitated <input type="checkbox"/> Lethargic
<p><b>Dehydration:</b> <b>Sunken eyes? Skin pinch</b> (select one)</p>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> >2 seconds <input type="checkbox"/> <2 seconds <input type="checkbox"/> Immediate
<p><b>Drinking/Breastfeeding)</b></p>	<input type="checkbox"/> <b>Normal</b> <input type="checkbox"/> Poorly <input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
<p><b>Abdomen</b> <i>(select any that apply)</i></p>	<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
<p><b>Signs of Rickets</b></p>	<input type="checkbox"/> Wrist <input type="checkbox"/> Swollen <input type="checkbox"/> Bow <input type="checkbox"/> Frontal <input type="checkbox"/> <b>None</b> <input type="checkbox"/> Rachitic rosary <div style="display: flex; justify-content: space-between; width: 100%;"> <span>widening</span> <span>knees</span> <span>legs</span> <span>bossing</span> </div>
<p><b>Jaundice</b></p>	<input type="checkbox"/> <b>Not jaundiced</b> <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++
<p><b>ENT/Oral/Eyes</b> <i>(select any that apply)</i></p>	<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
<p><b>Skin</b> <i>(select any that apply)</i></p>	<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/ papular
<p><b>Site of skin lesions.</b> <i>(select any that apply)</i></p>	<input type="checkbox"/> Not applicable <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs (No rash) <input type="checkbox"/> Palms / Soles <input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum



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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

Immediate Clinical Investigations						
<b>Malaria RDT</b> <i>circle result</i>	Positive		Negative		Not done	
<b>Blood glucose</b>	_____ . _____ mmol /L		<b>Time glucose measure</b>		_____ : _____ 24h clock <input type="checkbox"/> Unknown	
<b>Urine Dipstick</b> <i>(can be done at any time during admission)</i>	Protein + ++ +++ None	Nitrites Pos Neg	Leucocytes + ++ +++ None	Blood + ++ +++ None	Ketones + ++ +++ None	Glucose + ++ +++ None
<input type="checkbox"/> Not done <input type="checkbox"/> Bag <input type="checkbox"/> Clean catch						

11. Suspected Initial Diagnoses:		
<p><i>Clinical diagnosis should be based on examination and investigation findings.</i></p> <p><i>Tick the <u>three most likely</u> diagnoses.</i></p>		
<b>Respiratory</b> <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 <b>General</b> <input type="checkbox"/> Anaemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Thalassaemia <input type="checkbox"/> Renal impairment <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Nephritis <input type="checkbox"/> Liver dysfunction <input type="checkbox"/> Ileus <input type="checkbox"/> Congenital cardiac disease <input checked="" type="checkbox"/> Haemolytic disease newborn <input checked="" type="checkbox"/> Neonatal jaundice	<b>Infection</b> <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> 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"/> Febrile illness unspecified <input type="checkbox"/> Enteric fever <input checked="" type="checkbox"/> Infected umbilicus	<b>CNS</b> <input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Epilepsy <input type="checkbox"/> Probable meningitis <input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Developmental delay <input type="checkbox"/> Cerebral palsy <b>Other suspected diagnosis:</b> <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Failed appetite test only <input checked="" type="checkbox"/> Breast-feeding difficulty





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	<input type="checkbox"/> Antimalarial (any)	<input type="checkbox"/> Albendazole / deworming
	<input type="checkbox"/> ReSoMal	<input type="checkbox"/> Other
	<input type="checkbox"/> ORS	_____

**Clinicians impression of risk**

*How likely does the clinical team think this child is to die during this admission? Select one*

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

**Readmission Sample Collection**

<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>Clinical chemistry taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Blood spot taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>EDTA 2ml blood taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Blood culture taken (if available at site)</b>	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> N <input type="checkbox"/> Y AFTER ABX
<b>EDTA 0.5ml blood taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Blood gas taken (if available at site)</b>	<input type="checkbox"/> Capillary <input type="checkbox"/> N <input type="checkbox"/> Venous
<b>Date Taken</b>	Date taken _____ Time taken ____:____ <i>DD / MM / YYYY</i>		

**Unable to take blood samples, why?**

Difficult venepuncture   
  Child uncooperative   
  Parent refused   
  Other

**Rectal swabs taken**

Y BEFORE ABX     \_\_\_\_\_  
 Number taken  1     2  
 Y AFTER ABX    N    Time taken \_\_\_\_:\_\_\_\_

**Stool sample**

Taken \_\_\_\_\_ Date taken \_\_\_\_\_  
 in  Y     N    \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 first \_\_\_\_\_ Time taken \_\_\_\_:\_\_\_\_  
*DD / MM / YYYY*  
 24h?

**Chest x-ray indicated**  
*(respiratory signs symptoms)*

Yes, but too unwell   
  Yes, done   
  Not indicated

**Lumbar puncture indicated**  
*(signs of meningitis documented)*

Yes, but too unwell   
  Yes, done   
  Not indicated

**Blood Samples taken by (initials)**

\_\_\_\_\_

**Rectal Swabs taken by (initials)**

\_\_\_\_\_



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