

CHAIN Number

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CHAIN / BREAST MILK Composition SUB-STUDY (BMC study)

BMC SITE NAME: _____

Time now: __: __

ENROLMENT

Eligibility checklist		
Infant enrolled in CHAIN	<input type="checkbox"/> yes	<input type="checkbox"/> no
Infant aged between 7 days and below 6 months at CHAIN enrolment	<input type="checkbox"/> yes	<input type="checkbox"/> no
Mother currently breastfeeding	<input type="checkbox"/> yes	<input type="checkbox"/> no
Mother breastfed the infants in the past 5 days	<input type="checkbox"/> yes	<input type="checkbox"/> no
Consent to BMC sub-study	<input type="checkbox"/> yes	<input type="checkbox"/> no
All of the above must be YES to be eligible for BMC sub-study		
Name of FW		
Date of Consent	___ / ___ / _____ <small>D D / M M / Y Y Y Y</small>	
Time of Consent	___:___ (hh:mm)	
Special Circumstances		
Mother is currently taking any nutrition supplements	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes, write names of the supplements the mother is taking: (Ask to see the supplement packaging and write the name of supplement)	<input type="checkbox"/> Unknown 1. 2. 3. 4.	
Time since mother took the last supplement?	<input type="checkbox"/> <1 hr <input type="checkbox"/> 1-3 hrs <input type="checkbox"/> 3-6 hrs <input type="checkbox"/> >6 hrs <input type="checkbox"/> Unknown	
Mother is currently taking any medicine	<input type="checkbox"/> yes	<input type="checkbox"/> no
Where did mother get medication from?	<input type="checkbox"/> Unknown <input type="checkbox"/> Hospital/clinic <input type="checkbox"/> Herbal/traditional <input type="checkbox"/> Pharmacy <input type="checkbox"/> Healer <input type="checkbox"/> Shop <input type="checkbox"/> Neighbour/friend	
If yes, list names of the medicine the mother is taking: (Ask to see medicine and write the names of the medicine)	<input type="checkbox"/> Unknown 1. 2. 3. 4.	
Mother is currently breastfeeding more than one child (e.g. twins)	<input type="checkbox"/> yes	<input type="checkbox"/> no

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Mothers Characteristic (currently collected in main CHAIN CRF)	
Age	<input type="checkbox"/> <18 years <input type="checkbox"/> >18 years
Education	<input type="checkbox"/> None <input type="checkbox"/> Some Primary <input type="checkbox"/> Completed Primary <input type="checkbox"/> Some Secondary <input type="checkbox"/> Completed Secondary <input type="checkbox"/> Above Secondary
HIV status in last 6 months	<input type="checkbox"/> Known + <input type="checkbox"/> Tested + <input type="checkbox"/> Tested - <input type="checkbox"/> Not Tested <input type="checkbox"/> Known -
If positive is mother on ART? <i>(If yes, ensure the names of the ART medications are listed under medications above)</i>	<input type="checkbox"/> yes <input type="checkbox"/> no
If positive is mother on cotrimoxazole or Septrin?	<input type="checkbox"/> yes <input type="checkbox"/> no
Mother's Anthropometry	MUAC: _____. ____ cm Height: _____ . ____ cm Weight: _____. ____ kg
Participants birth order	____ of ____ live births
Age at first pregnancy	____ years <input type="checkbox"/> unknown
Marital status	<input type="checkbox"/> Married monogamous <input type="checkbox"/> Married polygamous <input type="checkbox"/> Stable relationship <input type="checkbox"/> Single <input type="checkbox"/> Unstable/complicated/separated relationship <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Mother has any long-term (chronic) known illness?	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, which disease? <input type="checkbox"/> Diabetes <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> Obesity <input type="checkbox"/> Other (specify) _____
Has mother taken any of the following in last 7 days?	<input type="checkbox"/> Alcohol <input type="checkbox"/> IV drugs <input type="checkbox"/> Khat <input type="checkbox"/> Cannabis <input type="checkbox"/> Tobacco <input type="checkbox"/> None <input type="checkbox"/> Other (specify) _____
Infant characteristics (currently collected in main CHAIN CRF)	

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Date of arrived at hospital	___/___/_____ D D / M M / Y Y Y Y
Date of sub-study enrolment	___/___/_____ D D / M M / Y Y Y Y
Date of birth	___/___/_____ D D / M M / Y Y Y Y
Is the date of birth	<input type="checkbox"/> true/recorded <input type="checkbox"/> estimated
Sex	<input type="checkbox"/> male <input type="checkbox"/> female
Birth details	<input type="checkbox"/> premature <input type="checkbox"/> born small <2.5kg <input type="checkbox"/> twin/multiple birth <input type="checkbox"/> born term <input type="checkbox"/> unknown
Gestational age	<input type="checkbox"/> known/recorded ___ weeks <input type="checkbox"/> estimated, reported ___ weeks <input type="checkbox"/> unknown

Birth weight	<input type="checkbox"/> known/recorded ___ . ___ Kg <input type="checkbox"/> estimated, reported ___ . ___ Kg <input type="checkbox"/> unknown
Birth length	<input type="checkbox"/> known/recorded, ___ . ___ cm <input type="checkbox"/> estimated, reported ___ . ___ cm <input type="checkbox"/> unknown
Mode of delivery	<input type="checkbox"/> unassisted vaginal delivery (normal) <input type="checkbox"/> assisted vaginal delivery (forceps) <input type="checkbox"/> c-section

Infant feeding

Breastfeeding frequency (24 hrs) before hospitalization	<input type="checkbox"/> <4 times a day <input type="checkbox"/> 4-8 times a day <input type="checkbox"/> >8 times a day
Breastfeeding frequency in the past 24 hrs?	<input type="checkbox"/> <4 times <input type="checkbox"/> 4-8 times <input type="checkbox"/> >8 times
Does mother avoid feeding the baby from one breast?	<input type="checkbox"/> yes <input type="checkbox"/> no
If YES, why?	<input type="checkbox"/> Pain <input type="checkbox"/> Other forms of discomfort <input type="checkbox"/> Baby preference <input type="checkbox"/> Other (specify) _____

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List other liquids sometimes consumed by infant before hospitalization?	<input type="checkbox"/> Nothing <input type="checkbox"/> Water <input type="checkbox"/> Sweetened water <input type="checkbox"/> Juice <input type="checkbox"/> Soda/fizzy drinks <input type="checkbox"/> Tea/cocoa <input type="checkbox"/> Formula milk <input type="checkbox"/> Soups <input type="checkbox"/> Gripe water <input type="checkbox"/> Herbal medicine <input type="checkbox"/> Special milk/DF100 <input type="checkbox"/> Honey <input type="checkbox"/> Cow's milk <input type="checkbox"/> Others
If YES to liquids, at what age did infant FIRST consume any liquids other than breast milk?	<input type="checkbox"/> Birth-day 5 <input type="checkbox"/> Day 5 – 2 weeks <input type="checkbox"/> >2 weeks to 1 month <input type="checkbox"/> 1 month – 3 months <input type="checkbox"/> >3 months
List other semi-solid foods consumed by infant before hospitalization?	<input type="checkbox"/> Porridge <input type="checkbox"/> Fruit purees <input type="checkbox"/> Vegetable purees <input type="checkbox"/> Others (list below) _____ _____
If YES to semi-solid foods, at what age did infant FIRST consume any semi-solids other than breast milk?	<input type="checkbox"/> Birth-day 5 <input type="checkbox"/> Day 5 – 2 weeks <input type="checkbox"/> >2 weeks to 1 month <input type="checkbox"/> 1 month – 3 months <input type="checkbox"/> >3 months
When child fell ill, did mother stop breastfeeding?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, what was given to the child instead?	<input type="checkbox"/> Other liquids (water, animal milk, formula, soups, juices, etc) <input type="checkbox"/> Semi-solids (porridge, fruit puree, etc)
How many days has child been ill?	___ ___ Number of days child has been ill

Early initiation of breastfeeding

What did the child receive other than breastmilk in the first 3 days of life?	<input type="checkbox"/> sweetened water <input type="checkbox"/> formula/powdered milk <input type="checkbox"/> animal milk <input type="checkbox"/> fruit juice <input type="checkbox"/> tea <input type="checkbox"/> water <input type="checkbox"/> pure honey <input type="checkbox"/> glycerine <input type="checkbox"/> nothing <input type="checkbox"/> porridge/pulp <input type="checkbox"/> others
Feeding of colostrum at birth	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
How early was colostrum/breastfeeding initiated	<input type="checkbox"/> Within 1 hour of birth <input type="checkbox"/> Between 1-12 hours <input type="checkbox"/> >12 hours
Colostrum difficult to obtain	<input type="checkbox"/> yes <input type="checkbox"/> no

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Who helped mother initiate breastfeeding?	<input type="checkbox"/> Nurse/midwife <input type="checkbox"/> Organised lactation support group <input type="checkbox"/> Infant's grandmother <input type="checkbox"/> Sister <input type="checkbox"/> Other family member <input type="checkbox"/> No one
How many children has she breastfed before this infant	<input type="checkbox"/> None/first child <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More than 3
Is mother currently pregnant	<input type="checkbox"/> yes, confirmed <input type="checkbox"/> no <input type="checkbox"/> suspected pregnancy <input type="checkbox"/> unknown

Breast assessment (as observed at the time of assessment)

Does the right breast look healthy?	<input type="checkbox"/> yes <input type="checkbox"/> no IF no, Nipples are cracked <input type="checkbox"/> slight <input type="checkbox"/> severe with bleeding
Does the left breast look healthy?	<input type="checkbox"/> yes <input type="checkbox"/> no IF no, Nipples are cracked <input type="checkbox"/> slight <input type="checkbox"/> severe with bleeding
Size and shape of nipples	Right nipple <input type="checkbox"/> inverted <input type="checkbox"/> flat <input type="checkbox"/> pointed on one end <input type="checkbox"/> round (normal) Left nipple <input type="checkbox"/> inverted <input type="checkbox"/> flat <input type="checkbox"/> pointed on one end <input type="checkbox"/> round (normal)

Size and shape of breast	Right breast <input type="checkbox"/> large <input type="checkbox"/> engorged and painful <input type="checkbox"/> full / rounded (normal) <input type="checkbox"/> flat / deflated <input type="checkbox"/> small Left breast <input type="checkbox"/> large <input type="checkbox"/> engorged and painful <input type="checkbox"/> full / rounded (normal) <input type="checkbox"/> flat / deflated <input type="checkbox"/> small
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Dripping milk	<input type="checkbox"/> yes <input type="checkbox"/> no
Signs of inflammation or infection (<i>tick all that apply</i>)	<input type="checkbox"/> redness <input type="checkbox"/> swollen <input type="checkbox"/> None <input type="checkbox"/> painful <input type="checkbox"/> fever/feeling ill <input type="checkbox"/> warm to the touch <input type="checkbox"/> thickening of breast tissue
Pain, burning or discomfort during breastfeeding	<input type="checkbox"/> yes <input type="checkbox"/> no
Breast oozes with milk mixed with pus or blood	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, which breast <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both
Mother noticed anything wrong with breast?	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, comment: _____
Mother thinks breast milk is sufficient for her baby?	<input type="checkbox"/> yes <input type="checkbox"/> no
Bottle feeding?	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, what is fed in a bottle? (<i>tick all that apply</i>) <input type="checkbox"/> breast milk at room temperature <input type="checkbox"/> warmed breast milk <input type="checkbox"/> animal milk <input type="checkbox"/> Formula milk <input type="checkbox"/> Other liquids e.g. Juices, etc.
Does the mother currently use hand expression?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> rarely <input type="checkbox"/> on occasion <input type="checkbox"/> often IF yes, why: <input type="checkbox"/> relieve engorgement <input type="checkbox"/> collect milk to feed the infant at a later time <input type="checkbox"/> aid in stimulation/production of milk

Breastfeeding assessment to be completed for all mothers and used to support feeding technique for all mothers at the end of the sample collection.

Breastfeeding assessment (Observed)

<i>Positioning</i>		<i>Attachment</i>	
Baby's head and body in line	<input type="checkbox"/> yes <input type="checkbox"/> no	More areola seen above baby's top lip	<input type="checkbox"/> yes <input type="checkbox"/> no
Baby held close to mother's body	<input type="checkbox"/> yes <input type="checkbox"/> no	Baby's mouth open wide	<input type="checkbox"/> yes <input type="checkbox"/> no
Baby's whole body supported	<input type="checkbox"/> yes <input type="checkbox"/> no	Lower lip turned outward	<input type="checkbox"/> yes <input type="checkbox"/> no

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Baby approaches breast nose to nipple	<input type="checkbox"/> yes <input type="checkbox"/> no	Baby's chin touches breast	<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Suckling</i>		<i>Mother</i>	
Slow deep sucks with pauses	<input type="checkbox"/> yes <input type="checkbox"/> no	Mother looks healthy	<input type="checkbox"/> yes <input type="checkbox"/> no
Cheeks round when suckling	<input type="checkbox"/> yes <input type="checkbox"/> no	Mother relaxed and comfortable	<input type="checkbox"/> yes <input type="checkbox"/> no
Baby releases breast when finished	<input type="checkbox"/> yes <input type="checkbox"/> no	Bonding with baby	<input type="checkbox"/> yes <input type="checkbox"/> no
Mother notices signs of oxytocin reflex (milk dripping by itself)	<input type="checkbox"/> yes <input type="checkbox"/> no		
Mothers Diet			
Is mother currently on nutrition programme	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mothers dietary habits	<input type="checkbox"/> Mixed diet <input type="checkbox"/> Vegetarian but with milk <input type="checkbox"/> Strictly vegetarian <input type="checkbox"/> Others		
What time did mother take breakfast this morning? (<i>indicate approximate time</i>)	___:___ (hh:mm) <input type="checkbox"/> None		
List all foods and liquids consumed as part of breakfast (include liquids)	<input type="checkbox"/> None 1. 2. 3. 4. 5.		
What time did you eat dinner last night? (<i>estimated time</i>)	___:___ (hh:mm) <input type="checkbox"/> None		
List all foods and liquids consumed as part of dinner (include liquids)	<input type="checkbox"/> None 1. 2. 3. 4. 5.		
List all foods and liquids consumed as snacks between dinner and breakfast (during the night)	<input type="checkbox"/> None 1. 2. 3. 4.		

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<p>In the past 7 days, did the mother consume at least 1 tablespoon of the following food?</p> <p>If yes, how many times?</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"><input type="checkbox"/> Yes</td> <td style="width: 15%;"><input type="checkbox"/> No</td> <td style="width: 15%;"></td> <td style="width: 15%; text-align: center;">Number of times</td> <td style="width: 20%;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td style="text-align: center;">[]</td> <td></td> </tr> <tr> <td style="text-align: right;">Pulses</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td style="text-align: right;">Nuts and seeds</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td style="text-align: right;">Dairy</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td style="text-align: right;">Meat, poultry and fish</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td style="text-align: center;">[]</td> <td></td> </tr> <tr> <td style="text-align: right;">Eggs</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td style="text-align: center;">[]</td> <td></td> </tr> <tr> <td style="text-align: right;">Dark green leafy vegetables</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td style="text-align: center;">[]</td> <td></td> </tr> <tr> <td style="text-align: right;">Yellow fruits and vegetables</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td style="text-align: center;">[]</td> <td></td> </tr> <tr> <td style="text-align: right;">Other fruits and vegetables</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Yes	<input type="checkbox"/> No		Number of times						[]		Pulses	<input type="checkbox"/> Yes	<input type="checkbox"/> No		[]	[]	Nuts and seeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No		[]	[]	Dairy	<input type="checkbox"/> Yes	<input type="checkbox"/> No		[]	[]	Meat, poultry and fish	<input type="checkbox"/> Yes	<input type="checkbox"/> No		[]		Eggs	<input type="checkbox"/> Yes	<input type="checkbox"/> No		[]		Dark green leafy vegetables	<input type="checkbox"/> Yes	<input type="checkbox"/> No		[]		Yellow fruits and vegetables	<input type="checkbox"/> Yes	<input type="checkbox"/> No		[]		Other fruits and vegetables					
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Other fruits and vegetables																																																													

Breastmilk collection	
Breastmilk collection attempted	<input type="checkbox"/> yes <input type="checkbox"/> no
Date of collection	___/___/_____ <i>DD / MM / YYYY</i>
Time of collection (start)	___:___ (hh:mm)
Time of collection (end)	___:___ (hh:mm)
More than 20ml was collected using only the first breast?	<input type="checkbox"/> yes <input type="checkbox"/> no
Amount of milk sample collected from first breast?	___mL
Which breast was used	<input type="checkbox"/> right <input type="checkbox"/> left
If second breast was used, total milk volume obtained after full hand expression of 2 nd breast	___mL <input type="checkbox"/> Not applicable

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Unable to collect 20ml breastmilk sample why?	<input type="checkbox"/> insufficient milk in the breast <input type="checkbox"/> difficulty in expressing <input type="checkbox"/> other (specify) _____
How to best describe the milk collection process	<input type="checkbox"/> Milk flow was fast and easy <input type="checkbox"/> Milk flow was slow and difficult
Was mother experienced in hand expression	<input type="checkbox"/> Experienced <input type="checkbox"/> Not experienced

CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i>	____	Date ____ / ____ / ____ <small>D D / M M / Y Y Y Y</small>	Time ____ : ____
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FOLLOW-UP DAY 45

Special Circumstances	
Mother is currently taking any nutrition supplements	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, write down names of the supplements the mother is taking: (Ask to see the supplement packaging and write the name of supplement)	<input type="checkbox"/> Unknown 1. 2. 3. 4.
Time since mother took the last supplement?	<input type="checkbox"/> <1 hr <input type="checkbox"/> 1-3 hrs <input type="checkbox"/> 3-6 hrs <input type="checkbox"/> >6 hrs <input type="checkbox"/> Unknown
Mother is currently taking any medicine	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, list names of the medicine the mother is taking: (Ask to see medicine and write the names of the medicine. IF mother is HIV positive, ensure names of ART medications are listed.)	<input type="checkbox"/> Unknown 1. 2. 3. 4.
Mother is currently breastfeeding more than one child (e.g. twins)	<input type="checkbox"/> yes <input type="checkbox"/> no
Current Breastfeeding status	
Is this child currently breastfeeding?	<input type="checkbox"/> yes <input type="checkbox"/> no
Breastfeeding frequency in the past 24 hrs?	<input type="checkbox"/> <4 times <input type="checkbox"/> 4-8 times <input type="checkbox"/> >8 times <input type="checkbox"/> N/A – no longer breastfeeding
If NO longer breastfeeding, age in months when child stopped breastfeeding	__ __ age in months
Reason for stopping breastfeeding?	<input type="checkbox"/> insufficient breastmilk <input type="checkbox"/> return to work/school <input type="checkbox"/> mother's illness <input type="checkbox"/> mother's death <input type="checkbox"/> fatigue <input type="checkbox"/> other reasons
Breast assessment	

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Does the right breast look healthy?	<input type="checkbox"/> yes <input type="checkbox"/> no IF no, Nipples are cracked <input type="checkbox"/> slight <input type="checkbox"/> severe with bleeding
Does the left breast look healthy?	<input type="checkbox"/> yes <input type="checkbox"/> no IF no, Nipples are cracked <input type="checkbox"/> slight <input type="checkbox"/> severe with bleeding
Size and shape of nipples	<p>Right nipple</p> <input type="checkbox"/> inverted <input type="checkbox"/> flat <input type="checkbox"/> pointed on one end <input type="checkbox"/> round (normal)
	<p>Left nipple</p> <input type="checkbox"/> inverted <input type="checkbox"/> flat <input type="checkbox"/> pointed on one end <input type="checkbox"/> round (normal)
Size and shape of breast	<p>Right breast</p> <input type="checkbox"/> large <input type="checkbox"/> engorged and painful <input type="checkbox"/> full / rounded (normal) <input type="checkbox"/> flat / deflated <input type="checkbox"/> small
	<p>Left breast</p> <input type="checkbox"/> large <input type="checkbox"/> engorged and painful <input type="checkbox"/> full / rounded (normal) <input type="checkbox"/> flat / deflated <input type="checkbox"/> small
Dripping milk	<input type="checkbox"/> yes <input type="checkbox"/> no
Signs of inflammation or infection (<i>tick all that apply</i>)	<input type="checkbox"/> redness <input type="checkbox"/> swollen <input type="checkbox"/> painful <input type="checkbox"/> fever/feeling ill <input type="checkbox"/> warm to the touch <input type="checkbox"/> None <input type="checkbox"/> thickening of breast tissue
Pain, burning or discomfort during breastfeeding	<input type="checkbox"/> yes <input type="checkbox"/> no
Breast oozes with milk mixed with pus or blood	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, which breast <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both

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Mother noticed anything wrong with breast?	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, comment: _____
Mother thinks breastmilk sufficient for her baby?	<input type="checkbox"/> yes <input type="checkbox"/> no
Bottle feeding?	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, what is fed in a bottle? <input type="checkbox"/> breast milk at room temperature <input type="checkbox"/> warmed breast milk <input type="checkbox"/> animal milk <input type="checkbox"/> Formula milk <input type="checkbox"/> Other liquids e.g. Juices, etc.
Does the mother currently use hand expression?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> rarely <input type="checkbox"/> on occasion <input type="checkbox"/> often If yes, why: <input type="checkbox"/> relieve engorgement <input type="checkbox"/> collect milk to feed the infant at a later time <input type="checkbox"/> aid in stimulation/production of milk

Mothers Diet	
Is mother currently on nutrition programme	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mothers dietary habits	<input type="checkbox"/> Mixed diet <input type="checkbox"/> Vegetarian but with milk <input type="checkbox"/> Strictly vegetarian <input type="checkbox"/> Others
What time did mother take breakfast this morning? (indicate approximate time)	__ __ : __ __ (hh:mm) <input type="checkbox"/> None
List all foods and liquids consumed as part of breakfast (include liquids)	<input type="checkbox"/> None 1. 2. 3. 4. 5.
What time did you eat dinner last night? (estimated time)	__ __ : __ __ (hh:mm) <input type="checkbox"/> None

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List all foods and liquids consumed as part of dinner (include liquids)	<input type="checkbox"/> None 1. 2. 3. 4. 5.
List all foods and liquids consumed as snacks between dinner and breakfast (during the night)	<input type="checkbox"/> None 1. 2. 3. 4.
Breastmilk collection	
Breastmilk collection attempted	<input type="checkbox"/> yes <input type="checkbox"/> no
Date of collection	___/___/_____ <i> D D / M M / Y Y Y Y </i>
Time of collection (start)	___:___ (hh:mm)
Time of collection (end)	___:___ (hh:mm)
More than 20ml was collected using only the first breast?	<input type="checkbox"/> yes <input type="checkbox"/> no
Amount of milk sample collected from first breast?	___mL
Which breast was used	<input type="checkbox"/> right <input type="checkbox"/> left
If second breast was used, total milk volume obtained after full hand expression of 2 nd breast	___mL <input type="checkbox"/> Not applicable
Unable to collect 20ml breastmilk sample why?	<input type="checkbox"/> insufficient milk in the breast <input type="checkbox"/> difficulty in expressing <input type="checkbox"/> other (specify) _____
How to best describe the milk collection process	<input type="checkbox"/> Milk flow was fast and easy <input type="checkbox"/> Milk flow was slow and difficult

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Was mother experienced in hand expression	<input type="checkbox"/> Experienced <input type="checkbox"/> Not experienced
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CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i>	_____ _____	Date ____/____/_____ <small>D D / M M / Y Y Y Y</small>	Time ____:____
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