



PB-SAM Number [1][0][0][0][3][][][][]

Day 60 Follow Up		
1. VISIT DETAILS		
1.1.	Date seen or contacted on phone?	___/___/_____ D D / M M / Y Y Y Y
1.2.	Time seen or contacted on phone	__:__:__ 24 hour clock
1.3.	Seen at (Select ONE)	<input type="checkbox"/> Hospital / clinic <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> In Community <input type="checkbox"/> Confirmed vital status phone - alive <input type="checkbox"/> Confirmed vital status phone – dead

2. ANTHROPOMETRY		
	Anthropometry done	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.1.	Weight (to be taken using SECA scales for CHAIN study)	___ __. ___ __ kg
2.2.	Length or height (Select ONE) (Length measured lying down if participant less than 24 months and height measured standing)	<input type="checkbox"/> Length <input type="checkbox"/> Height (to be taken using SECA 416 infantometer provided for study) Measurer 1: ___ __. ___ __ cm Measurer 2: ___ __. ___ __ cm
2.3.	MUAC (To be taken using MUAC tape for CHAIN study)	Measurer 1: ___ __. ___ __ cm Measurer 2: ___ __. ___ __ cm
2.4.	Head circumference (To be taken using CHAIN measuring tape)	Measurer 1: ___ __. ___ __ cm Measurer 2: ___ __. ___ __ cm
2.5.	Oedema (Select all that apply)	<input type="checkbox"/> None <input type="checkbox"/> both feet/ankles <input type="checkbox"/> lower legs <input type="checkbox"/> hands or lower arms <input type="checkbox"/> face
2.6.	Growth changes consistent with previous measurements? (Select ONE)	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, consider to be wrong measurement, child or file)
2.7.	Staff Initials	Measurer 1: ___ __ Measurer 2: ___ __

3. HOSPITAL ADMISSIONS		
3.1.	Any admissions (e.g. overnight stay) to a hospital since DAY 21?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Complete SAE form)
	If Yes a) Admission date 1	___/___/_____ D D / M M / Y Y Y Y



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	<i>(If not known, estimate)</i>	D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 1	___ / ___ / ___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	d) Source of information 1	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
3.2.	If Second re-admission	<input type="checkbox"/> Not applicable
	a) Re-admission date 2 <i>(If not known, estimate)</i>	___ / ___ / ___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Date of discharge 2	___ / ___ / ___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	e) Source of information 1	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
3.3.	If third re-admission	<input type="checkbox"/> Not applicable
	a) 3rd Re-admission date <i>(If not known, estimate)</i>	___ / ___ / ___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 2	<input type="checkbox"/> Not applicable ___ / ___ / ___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Source of information 1	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report

4. CURRENT HEALTH

4.1.	a) What symptoms were noticed in the last 7 days? <i>If any meet criteria for 3 or 4 toxicity, then a toxicity CRF must also be filled. Refer to SAE and Toxicity SOP.</i> <i>(Select all that apply)</i>	<input type="checkbox"/> No symptoms, child is well <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Cough <input type="checkbox"/> Difficulties with feeding/loss of appetite <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Yellowness of skin/eyes <input type="checkbox"/> Rash / skin lesion
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5. MEDICATIONS AT DAY 60

5.1.	Enzyme/Placebo	
	a) Given:	_ sachets



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	b) Used: c) Returned:	__ __ sachets __ __ sachets
5.2.	Urso/Placebo: a) Bottle 1 i). Weight	__ __ __ grams <input type="checkbox"/> Used completely <input type="checkbox"/> Partly Used <input type="checkbox"/> Returned as unused
	ii). Usage	
	b) Bottle 2 i). Weight	<input type="checkbox"/> Not applicable, only one bottle given __ __ __ grams <input type="checkbox"/> Used completely <input type="checkbox"/> Partly Used <input type="checkbox"/> Returned as unused
	ii). Usage	

6. FEEDING		
6.1.	Currently in outpatient nutrition program? <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
6.2.	Attended a Nutrition follow-up appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.3.	Has the child eaten the following nutrition products in the last 3 days?	<input type="checkbox"/> Supplementary <input type="checkbox"/> Therapeutic <input type="checkbox"/> None

7. D60 INVESTIGATIONS AND SAMPLE COLLECTIONS		
7.1.	a) Rectal swabs taken	<input type="checkbox"/> Y BEFORE ABX <i>(ABX=Antibiotics)</i> <input type="checkbox"/> Y AFTER ABX <input type="checkbox"/> No
	b) Time Rectal swabs taken	____: ____
7.2.	Stool sample taken	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.3.	Rectal Swabs taken by (initials)	<input type="checkbox"/> N/A ____
7.4.	Stool taken by (initials)	<input type="checkbox"/> N/A ____



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8. CRF COMPLETION		
8.1.	a) CRF Completed by (Initials) – to be signed when complete <i>Do not sign if any fields are empty</i>	_____
	b) Date	____/____/_____ <i>D D / M M / Y Y Y Y</i>
	c) Time <i>(24 hr clock)</i>	____:____