

Enrolment date \_\_\_/\_\_\_/\_\_\_ (DD/MM/YYYY)

Child's Initials \_\_\_ \_\_

Date seen DD/MM		___/___	___/___	___/___	___/___	___/___	___/___	___/___	
Time seen (24h clock)		___:___	___:___	___:___	___:___	___:___	___:___	___:___	
<b>1. Clinical Events in the last 24h</b>									
<b>DANGER SIGNS</b>  at any time in last 24h?  <i>If bloods were taken by the clinical team then document results, do not retake bloods unless needed for clinical care</i>	1.1	No danger signs	○	○	○	○	○	○	
	1.2	Obstructed breathing	Y N	Y N	Y N	Y N	Y N	Y N	
	1.3	Lower chest wall indrawing	Y N	Y N	Y N	Y N	Y N	Y N	
	1.4	Cyanosis	Y N	Y N	Y N	Y N	Y N	Y N	
	1.5	Fast and Weak Pulse*	Y N	Y N	Y N	Y N	Y N	Y N	
	1.6	Capillary Refill >3 secs	Y N	Y N	Y N	Y N	Y N	Y N	
	1.7	Core/Limb Temp Gradient	Y N	Y N	Y N	Y N	Y N	Y N	
	1.8	Severe Anaemia*	Y N	Y N	Y N	Y N	Y N	Y N	
	1.9	Convulsion(s)	Y N	Y N	Y N	Y N	Y N	Y N	
	1.10	Lowest AVPU in last 24h	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U	
	1.11	Profuse Watery Diarrhoea	Y N	Y N	Y N	Y N	Y N	Y N	
	1.12	Vomits Everything	Y N	Y N	Y N	Y N	Y N	Y N	
	1.13	Severe Dehydration	Y N	Y N	Y N	Y N	Y N	Y N	
1.14	Temperature >38°C in last 24h	Y N	Y N	Y N	Y N	Y N	Y N		
1.15	Temperature <36°C in last 24h	Y N	Y N	Y N	Y N	Y N	Y N		
1.16	NG tube feeding in last 24h	Y N	Y N	Y N	Y N	Y N	Y N		
1.17	Any EBM or breastfeeding last 24h	Y N	Y N	Y N	Y N	Y N	Y N		
1.18	ReSoMal or ORS given in last 24h	Y N	Y N	Y N	Y N	Y N	Y N		
1.19	IV fluids given in last 24h	Y N	Y N	Y N	Y N	Y N	Y N		
1.20	Blood transfusion in last 24h	Y N	Y N	Y N	Y N	Y N	Y N		
1.21	Oxygen given in last 24h?	Y N	Y N	Y N	Y N	Y N	Y N		
1.22	CPAP given in last 24h?	Y N	Y N	Y N	Y N	Y N	Y N		
<b>2. CLINICAL OBSERVATIONS NOW</b>									
2.1	Oedema now (circle all that apply)	Feet Hands	Legs Arms	Feet Hands	Legs Arms	Feet Hands	Legs Arms	Feet Hands	Legs Arms
2.2	On oxygen now	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.3	On CPAP now	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.4	Oxygen saturation now	___%	___%	___%	___%	___%	___%	___%	___%
2.5	Respiratory rate now	___/min	___/min	___/min	___/min	___/min	___/min	___/min	___/min
2.6	Heart rate now	___/min	___/min	___/min	___/min	___/min	___/min	___/min	___/min
2.7	AVPU now (circle one)	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U
2.8	Temperature now	___°C	___°C	___°C	___°C	___°C	___°C	___°C	___°C
2.9	In PICU/ HDU now	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.10	In a surgical or specialist unit now	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.11	Currently NO FEEDS by mouth or tube	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.12	Currently on F75/equivalent	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.13	Currently on F100/equivalent	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.14	Currently on RUTF	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.15	On infant formula or dilute F100	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.16	On non-standard formula milk e.g. soya	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2.17	Currently receiving IV fluids	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N

\* Fast pulse = 1m to 1y: >150bpm; 1y to 5y: >110bpm; 6y to 11y: >95bpm. Severe anaemia = Hb <5g/dl

	Date seen DD/MM	/	/	/	/	/	/	/
2.18	Doses of Ursodeoxycholic acid given since the last assessment?	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
2.19	Doses of Pancreatic enzymes given since the last assessment?	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
<b>3. IV ANTIMICROBIALS IN LAST 24H</b>								
3.1	Crystalline / benzylpenicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.2	Ampicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.3	Gentamicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.4	Ceftriaxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5	Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.6	Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.7	(e.g. Augmentin) Co-Amoxiclav	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.8	Chloramphenicol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.9	Cefotaxime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.10	Ceftazidime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.11	Cefepime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.12	Flucloxacillin/Cloxacillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.13	Meropenem/Imipenem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.14	Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.15	Pivmecillinam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.16	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.17	Confirm if no iv Antibiotics given	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>2. ORAL ANTIMICROBIALS IN LAST 24H</b>								
4.1	Oral Amoxicillin/Ampiclox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2	Co-Amoxiclav (e.g. Augmentin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.3	Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.4	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.5	Azithromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.6	Oral Cephalosporin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.7	Co-trimoxazole treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.8	Co-trimoxazole prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.9	Nitrofurantoin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.10	Nalidixic acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.11	Clindamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.12	Metronidazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.13	Pivmecillinam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.14	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.15	Confirm if no oral Antibiotics given	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Date seen <i>DD/MM</i>	___/___	___/___	___/___	___/___	___/___	___/___	___/___
<b>3. OTHER DRUGS IN LAST 24H</b>								
5.1	Zidovudine/azidothymidine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.2	Lamivudine (3TC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3	Abacavir (ABC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.4	Nevirapine (NVP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.5	Efavirenz (EFV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.6	Lopinavir/Ritonavir (Kaletra)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.7	Phenobarbital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.8	Valproic acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.9	Levetiracetam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.10	Lamotrigine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.11	Hydroxyurea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.12	Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.13	Rifampicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.14	Pyrazinamide (PZA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.15	Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.16	Nystatin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.17	Fluconazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.0	Does clinical events require filling out an SAE form?	Y N	Y N	Y N	Y N	Y N	Y N	Y N
6.1	Clinician's initials	_____	_____	_____	_____	_____	_____	_____
6.2	Reviewer's initials	_____	_____	_____	_____	_____	_____	_____