

Enrolment date ___/___/___ (DD/MM/YYYY)

Child's Initials ___

Date seen DD / MM		___/___	___/___	___/___	___/___	___/___	___/___	___/___
Time seen (24h clock)		___:___	___:___	___:___	___:___	___:___	___:___	___:___
1. Clinical Events in the last 24h								
DANGER SIGNS 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	
2. CLINICAL OBSERVATIONS NOW								
2.1	Oedema now (circle all that apply)	Feet Hands Face	Legs Arms	Feet Hands Face	Legs Arms	Feet Hands Face	Legs Arms	Feet Hands Face
2.2	On oxygen now	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
2.4	Oxygen saturation now	___%	___%	___%	___%	___%	___%	___%
2.5	Respiratory rate now	___/min	___/min	___/min	___/min	___/min	___/min	___/min
2.6	Heart rate now	___/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
2.8	Temperature now	___ °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
2.10	In a surgical or specialist unit now	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
2.12	Currently on F75/equivalent	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
2.14	Currently on RUTF	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
2.16	On non-standard formula milk e.g. soya	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

* 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
3. IV ANTIMICROBIALS IN LAST 24H								
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"/>
2. ORAL ANTIMICROBIALS IN LAST 24H								
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>	___/___	___/___	___/___	___/___	___/___	___/___	___/___
3. OTHER DRUGS IN LAST 24H								
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	_____	_____	_____	_____	_____	_____	_____