Child Initials | | | |

FLACSAM
First Line Antimicrobials in Children with Complicated Severe Acute Malnutrition

F	1	2	7	5

FLACSAM: Discharge from Hospital

Discharge Details				
Discharge date:	___ __ / __ __ / __ __ __ ___ *D D / M M / Y Y Y Y*	(e.g. clinical decision / absconded /discharged against medical advice /referral/death)		
Discharge type: *(tick one)*	☐ **Clinical decision** ☐**Absconded** ☐ **Discharge against medical advice** ☐**Referral** ☐ **Death**			
Date last seen by research team	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*	**Phone number for follow-up**	☐ Y	☐ N
Date left hospital	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y*	**Completed HH locator form**	☐ Y	☐ N

Randomised Medications	
Penicillin Penicillin was received for __ __ calendar days ***(Including the day of admission and if any doses were given after the last daily record)*** OR ☐ Not randomised to penicillin	**If penicillin was given for less than 7 days, reason:** ☐ Changed to another antibiotic because of confirmed resistance ☐ Changed to another antibiotic because of deterioration/indication ☐ Changed because of improvement/ discharged ☐ Child died or was transferred ☐ Adverse reaction ☐ Absconded ☐ Other _____
Gentamicin Gentamicin was received for __ __ calendar days ***(Including the day of admission and if any doses were given after the last daily record)*** OR ☐ Not randomised to gentamicin	**If gentamicin was given for less than 7 days, reason:** ☐ Changed to another antibiotic because of confirmed resistance ☐ Changed to another antibiotic because of deterioration/indication ☐ Changed because of improvement/ discharged ☐ Child died or was transferred ☐ Adverse reaction ☐ Absconded ☐ Other _____

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Ceftriaxone Ceftriaxone was received for__ __ calendar days. ***(Including the day of admission and if any doses were given after the last daily record)*** OR ☐ Not randomised to ceftriaxone	**If ceftriaxone was given for less than 7 days, reason:** ☐ Changed to another antibiotic because of confirmed resistance ☐ Changed to another antibiotic because of deterioration/indication ☐ Changed because of improvement/ discharged ☐ Child died or was transferred ☐ Adverse reaction ☐ Absconded ☐ Other _____
Metronidazole/Placebo ☐ Metronidazole/ Placebo was **GIVEN FOR 7 DAYS** in hospital before discharge	
☐ Metronidazole/ Placebo was **NOT GIVEN FOR 7 DAYS** in hospital **BUT GIVEN** to continue at home	**If metronidazole/placebo was given for less than 7 days in hospital but given to continue at home:** Oral metronidazole/placebo was given for __ __ calendar days in hospital Oral metronidazole/placebo provided for __ __ calendar days at home
☐ Metronidazole/Placebo **WAS STOPPED BEFORE 7 DAYS** in hospital and **NOT GIVEN** to continue at home	**If metronidazole/placebo was given for less than 7 days in total:** Oral metronidazole/placebo was given for __ __ calendar days in hospital **REASON *TICK ONE*:** ☐ Changed to open label metronidazole ☐ Child died or was transferred ☐ Absconded ☐ Adverse reaction ☐ Other_____

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Medication at discharge

☐ Not applicable (for deaths only)

☐ No treatment

☐ Oral Amoxicillin for __ __ days

☐ Anti-TB therapy

☐ Other antibiotic_____

☐ Co-trimoxazole prophylaxis

☐ Anti-retroviral therapy

☐ Deworming

Final Diagnosis at Discharge

Tick up to THREE diagnoses.

Respiratory

☐ LRTI/pneumonia
☐ Bronchiolitis
☐ URTI
☐ Pulmonary TB
☐ Otitis media
☐ Asthma
☐ Aspiration e.g. of feed

General

☐ Anaemia
☐ Sickle Cell Disease
☐ Renal impairment
☐ Nephrotic syndrome
☐ Nephritis
☐ Liver dysfunction
☐ Ileus
☐ Cardiac disease

Infection

☐ Gastroenteritis
☐ Sepsis
☐ Confirmed Malaria
☐ Extra pulmonary TB
☐ Soft tissue infection
☐ UTI
☐ HIV related illness
☐ Measles
☐ Varicella
☐ Osteomyelitis
☐ Confirmed enteric fever
☐ Febrile illness unspecified
☐ Typhoid/paratyphoid with perforation

☐ Bacterial pathogen(s)isolated
(complete microbiology CRF)

CNS

☐ Febrile convulsions
☐ Epilepsy
☐ LP confirmed meningitis
☐ Clinically suspected meningitis
☐ Other encephalopathy
☐ Hydrocephalus
☐ Developmental delay unspecified
☐ Cerebral palsy
☐ Congenital syndrome

Other diagnosis:

☐Failed appetite test only/malnutrition only

☐Suspected drug toxicity
(if due to study drug, complete toxicity CRF)

☐Other known diagnosis
_____

☐Unknown diagnosis

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Anthropometry at Discharge

☐ Anthropometry not done

Weight	___ ___ . ___ ___kg	**Oedema**	☐ None ☐ + ☐ ++ ☐ +++
MUAC	____ ____ . ____ cm	**Length/Height**	____ ____ ____ . ____ cm ☐ Length ☐ Height
Measured by (initials)	___ ___ ___		☐ Length measurement not possible due to physical reasons

Nutrition and follow-up

☐ Not applicable (For deaths only)

Discharged to nutrition program? *(tick one)*	☐ None	☐ Therapeutic	☐ Supplementary
Discharged carrying *(tick all that apply)*	☐ None	☐ RUTF	☐ Supplementary feed
Any nutrition counselling during admission?	☐ Y	☐ N	
Any breastfeeding counselling during admission?	☐ Y	☐ N	
Breastfeeding at discharge?	☐ Y	☐ N	
Is the child receiving feeds other than breast milk	☐ Y	☐ N	

CLINICIAN'S IMPRESSION OF RISK

☐ Not applicable (For deaths only)

What does the clinical team think the risk of mortality is during follow up to 90 days? Select one

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

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Study Samples

☐ Not applicable (for deaths only)

Date blood samples taken	__ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y*		
EDTA 0.5ml *(whole blood)*	☐ Y	☐ Low Volume	☐ N
EDTA 1ml *(plasma)*	☐ Y	☐ Low Volume	☐ N
Sodium Heparin 1ml *(plasma)*	☐ Y	☐ Low Volume	☐ N
Unable to take blood samples, why?	☐ N/A ☐ Difficult venepuncture ☐ Other	☐ Child uncooperative ☐ Parent refused	
Rectal swabs taken *(should be two)*	☐ For culture (transport media) ☐ For storage (dry) ☐ N	**Date Taken:**	__ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y*
Stool sample taken	☐ Y ☐ N	**Date Taken:**	__ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y*
Blood Samples taken by *initials*	__ __ __		
Rectal Swabs taken by *initials*	__ __ __		
Stool sample taken by *initials*	__ __ __		

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Follow Up

☐ Not applicable (For deaths only)

Next follow up date is: *Follow up may have been done already if inpatient stay exceeded 14 days.*	☐ Day 14 ☐ Day 45 ☐ Day 90	Date __ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y*
Is there a change in the client's contact details? *(Any changes in the client contact details to be entered in the Household Locator form)*	☐ Y ☐ N	
Discharge CRF Completed by *initials*	___ ___ ___	Date __ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y*

END OF DISCHARGE CRF