

Child Initials

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FLACSAM: DAY 90

- Note that this follow up should be done even if the participant is still in hospital.
- If it is only possible to confirm vital status by phone (participant is travelling) then ask and complete all the questions except the anthropometry and the samples.

Follow up at 90 days post-enrolment			
DATE SEEN:	___ / ___ / ___ <small>D D / M M / Y Y Y Y</small>	TIME SEEN:	___ : ___ <small>24H Clock</small>
Seen at:	<input type="checkbox"/> Study clinic <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> In community <input type="checkbox"/> Confirmed vital status by phone/verbal report		

Anthropometry and Oedema			
<input type="checkbox"/> Anthropometry Not Done			
Weight	___ . ___ kg	Oedema	<input type="checkbox"/> None <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++
MUAC	___ . ___ cm	Length/Height	<input type="checkbox"/> Length ___ . ___ cm <input type="checkbox"/> Height
Measured by (initials)	___	<input type="checkbox"/> Length measurement not possible due to physical reasons	

Clinic Visits and Hospital Admissions	
How many times since day 45 has the child been taken to a nutrition clinic? <small>(number of times, indicate 0 if none)</small>	At study hospital ___ Other nutrition clinics ___
How many times since day 45 has the child been taken to a specialist clinic because of illness? <small>(number of times, indicate 0 if none) (Tick all that apply)</small>	At study hospital ___ Other clinics ___ <input type="checkbox"/> HIV <input type="checkbox"/> TB <input type="checkbox"/> Cardiac <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Neuro <input type="checkbox"/> Other
How many times since day 45 has the child been taken to a clinic because of acute illness? <small>(number of times, indicate 0 if none)</small>	Study clinic ___ Other clinics ___
How many times since day 45 has the child been admitted to hospital? <small>(number of times, indicate 0 if none)</small>	Study hospital ___ Non-study hospital ___

If a child has been admitted, this is an SAE – complete an SAE form for every admission to give details of diagnosis and outcome

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Current Health

Child in usual state of health now?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If No, length of current illness	Number of days: ___
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What are the MAIN symptoms present now?

No symptoms, child is well

<input type="checkbox"/> Fever / Hotness of body	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Lethargy
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Diarrhoea <14 days	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Cough <14 days	<input type="checkbox"/> Diarrhoea >14 days	<input type="checkbox"/> Altered consciousness
<input type="checkbox"/> Cough >14 days	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Not feeding (or failed appetite test)
<input type="checkbox"/> Poor feeding/ Weight loss	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Body swelling/bilateral limb swelling/bilateral oedema
<input type="checkbox"/> Rash/skin lesion	<input type="checkbox"/> Other _____	

Medication last 7 days. <i>tick any that apply</i>	<input type="checkbox"/> No medication	<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Antimalarial	<input type="checkbox"/> IV fluids
	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Anticonvulsants	<input type="checkbox"/> Anti-TB	<input type="checkbox"/> ARVs/ARTs
	<input type="checkbox"/> Traditional or Herbal	<input type="checkbox"/> Co-trimoxazole Prophylaxis	<input type="checkbox"/> Deworming	
	<input type="checkbox"/> Yes, but unknown	<input type="checkbox"/> Other _____		

Household health

Since the last scheduled study contact has anyone in the household had a serious illness/hospitalisation/ died?	<input type="checkbox"/> Y	<input type="checkbox"/> N
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TB Screening

Known TB (on treatment)	Child has cough >14 days	Household contact has TB, or cough >14 days	Child has suspected extra-pulmonary TB
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Feeding

Currently in outpatient nutrition program? <i>(Select one)</i>	<input type="checkbox"/> None	<input type="checkbox"/> Supplementary <i>(corn soy blend, RUSF)</i>	<input type="checkbox"/> Therapeutic <i>(RUTF, Plumpy-nut)</i>
Has the child eaten these nutrition products in the last 3 days?	<input type="checkbox"/> None	<input type="checkbox"/> Supplementary	<input type="checkbox"/> Therapeutic
Currently Breastfeeding?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is the child receiving feeds other than breast milk <i>(exclude medicine)?</i>	<input type="checkbox"/> Y <input type="checkbox"/> N

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D90 Sample Collection

Rectal swabs taken (Take TWO)	<input type="checkbox"/> For culture (transport media) <input type="checkbox"/> For storage (dry) <input type="checkbox"/> N	Date Taken:	____/____/_____ <small>D D / M M / Y Y Y Y</small>
Rectal swab taken by <i>initials</i>	_____		

D90 CRF completed by <i>Initials</i>	_____	Date ____/____/_____ <small>D D / M M / Y Y Y Y</small>	Time ____:____
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**THIS IS THE END OF THE STUDY – PLEASE COMPLETE THE STUDY CONCLUSION PAGE
THEN CHECK ALL DATA IN THE CRF IS COMPLETE**