

Child Initials

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FLACSAM: Serious Adverse Event

SAE Initial Details	
DATE of onset	___/___/___ <i>D D/M M/ Y Y Y Y</i>
DATE seen by research team	___/___/___ <i>D D/M M/ Y Y Y Y</i>
Classification at presentation <i>When the study team first became aware of the SAE. Tick the highest <u>one</u> applicable</i>	<input type="checkbox"/> Death <input type="checkbox"/> Readmission to study hospital <input type="checkbox"/> Readmission to non-study hospital <input type="checkbox"/> Readmission is indicated but parent/carer declines admission <input type="checkbox"/> Life-threatening event <input type="checkbox"/> Persistent or significant disability/incapacity <input type="checkbox"/> Event that prolongs hospitalisation whilst already in hospital <input type="checkbox"/> Other serious medical event where medical intervention was required to prevent any of the above e.g. TB, sickle cell disease
Reported by <i>(Tick one)</i>	<input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Health Professional <input type="checkbox"/> From medical records or discharge letter
On study drugs at onset? <i>(tick all that apply)</i>	<input type="checkbox"/> No <input type="checkbox"/> Penicillin <input type="checkbox"/> Gentamicin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Metronidazole/Placebo
Any other medication in the last 7 days? <i>(tick all 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"/> Yes, but unknown <input type="checkbox"/> Other _____
Currently in a nutrition program? <i>tick one</i>	<input type="checkbox"/> No <input type="checkbox"/> Supplementary Outpatient (corn soy blend, RUSF) <input type="checkbox"/> Therapeutic Outpatient (RUTF, Plumpy-nut) <input type="checkbox"/> Therapeutic in hospital
SUMMARY: <i>What was the event, when did it occur, where did it occur, was there any relation to study drug administration or other study procedure</i>	
<i>Relevant clinical findings</i>	
<i>Relevant laboratory findings</i>	
<i>Action taken</i>	

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SAE Conclusion

End date <i>(dd/mm/yyyy)</i>	____ / ____ / ____ or if no end date, <input type="checkbox"/> On-going & receiving care <input type="checkbox"/> Unknown <i>D D / M M / Y Y Y Y</i>
Final Classification <i>Tick the highest one applicable</i>	<input type="checkbox"/> Death <input type="checkbox"/> Readmission to study hospital <input type="checkbox"/> Readmission to non-study hospital <input type="checkbox"/> Readmission is indicated but parent/carer declines admission <input type="checkbox"/> Life-threatening event <input type="checkbox"/> Persistent or significant disability/incapacity <input type="checkbox"/> Event that prolongs hospitalisation whilst already in hospital <input type="checkbox"/> Other serious medical event where medical intervention was required to prevent any of the above e.g. TB, sickle cell disease
Was this event a suspected unexpected serious adverse reaction (SUSAR)?	
<input type="checkbox"/> Y <input type="checkbox"/> N	
Relationship of the event to study drugs	
No temporal relationship to drug and alternate aetiology (clinical state, environmental or other interventions); and does not follow known pattern of response to study product	<input type="checkbox"/> No Relationship
Unlikely temporal relationship to drug and alternate aetiology likely (clinical state, environmental or other interventions) and does not follow known typical or plausible pattern of response to drug.	<input type="checkbox"/> Unlikely
Reasonable temporal relationship to drug; or event not readily produced by clinical state, environmental or other interventions; or similar pattern of response to that seen with other drugs	<input type="checkbox"/> Possible
Reasonable temporal relationship to drug; and event not readily produced by clinical state, environment, or other interventions or known pattern of response seen with other drugs	<input type="checkbox"/> Probable
Reasonable temporal relationship to drug; and event not readily produced by clinical state, environment, or other interventions; and known pattern of response seen with other drugs	<input type="checkbox"/> Definite

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Diagnosis of the causes of the SAE

Do not include unchanged conditions that existed prior to the SAE. Tick up to THREE diagnoses.

Respiratory	Infection	CNS
<input type="checkbox"/> LRTI/pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> URTI <input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Otitis media <input type="checkbox"/> Asthma <input type="checkbox"/> Aspiration e.g. of feed	<input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> Confirmed Malaria <input type="checkbox"/> Extra pulmonary TB <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> UTI <input type="checkbox"/> HIV related illness <input type="checkbox"/> Measles <input type="checkbox"/> Varicella <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Confirmed enteric fever <input type="checkbox"/> Febrile illness unspecified <input type="checkbox"/> Bacterial pathogen(s) isolated <i>(complete microbiology CRF)</i>	<input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Epilepsy <input type="checkbox"/> LP confirmed meningitis <input type="checkbox"/> Clinically suspected meningitis <input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Developmental delay unspecified <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Congenital syndrome
General		Other diagnosis:
<input type="checkbox"/> Anaemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Renal impairment <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Nephritis <input type="checkbox"/> Liver dysfunction <input type="checkbox"/> Ileus <input type="checkbox"/> Cardiac disease		<input type="checkbox"/> Failed appetite test only/Malnutrition only. <input type="checkbox"/> Suspected drug toxicity <i>(if due to study drug, complete toxicity CRF)</i> <input type="checkbox"/> Other known diagnosis <hr/> <input type="checkbox"/> Unknown diagnosis

SAE CRF completed by	Date	Time
<i>initials</i>	___/___/_____ <i>D D / M M / Y Y Y Y</i>	___:___ <i>24 h clock</i>

END of SAE CRF

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Additional notes (*Not for entry into database*) ***all entries should be initialled and dated***