

PB-SAM Enrolment CRF v1.2



Patient Initials [][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

1. ELIGIBILITY CHECKLIST			
1.1. Inclusion Criteria			
		YES	NO (ineligible)
a)	Age between 2 months and 59 months	<input type="checkbox"/>	<input type="checkbox"/>
b)	Admitted to hospital with an acute non-traumatic illness (<i>Within this time, children requiring CPR or unable to take orally (NPO) will be re-evaluated daily</i>)	<input type="checkbox"/>	<input type="checkbox"/>
c)	Enrolled within 72 hours of admission	<input type="checkbox"/>	<input type="checkbox"/>
d)	Severe malnutrition (weight for height < -3z scores of the median WHO growth standards and/or MUAC <ul style="list-style-type: none"> • Age > 6months <115mm • 2- <6 months <110mm or symmetrical oedema of at least the feet related to malnutrition, i.e. not related to a primary cardiac or renal disorder)	<input type="checkbox"/>	<input type="checkbox"/>
e)	Parent or guardian able and available to consent	<input type="checkbox"/>	<input type="checkbox"/>
f)	Able to feed orally in usual state of health	<input type="checkbox"/>	<input type="checkbox"/>
g)	Presence of two or more features of severity as specified in Table below**	<input type="checkbox"/>	<input type="checkbox"/>
h)	Primary caregiver plans to stay in the study area during the duration of the study	<input type="checkbox"/>	<input type="checkbox"/>
1.2. Exclusion Criteria			
		YES (Ineligible)	NO
a)	Known congenital syndrome	<input type="checkbox"/>	<input type="checkbox"/>
b)	Cleft palate	<input type="checkbox"/>	<input type="checkbox"/>
c)	Known congenital cardiac disease	<input type="checkbox"/>	<input type="checkbox"/>
d)	Known terminal illness e.g. cancer	<input type="checkbox"/>	<input type="checkbox"/>
e)	Admission for surgery, or likely to require surgery within 6m	<input type="checkbox"/>	<input type="checkbox"/>
f)	Admission for trauma?	<input type="checkbox"/>	<input type="checkbox"/>
g)	Sibling enrolled in study	<input type="checkbox"/>	<input type="checkbox"/>
h)	Previously enrolled in this trial or currently enrolled in this trial	<input type="checkbox"/>	<input type="checkbox"/>
i)	Known stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
j)	Known liver disorder or exocrine pancreatic disorder – e.g. biliary atresia, history of gallstones, cystic fibrosis or clinical jaundice	<input type="checkbox"/>	<input type="checkbox"/>
k)	Known intolerance or allergy to any study medication	<input type="checkbox"/>	<input type="checkbox"/>
l)	<input type="checkbox"/> Direct Bilirubin levels Above 25 $\mu\text{mol/L}$ (Kampala site only)	<input type="checkbox"/>	<input type="checkbox"/>

PB-SAM Enrolment CRF v1.2



Patient Initials [][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

****Severity characteristics, two or more are required for enrolment**

a) <input type="checkbox"/> Respiratory distress	<input type="checkbox"/> subcostal indrawing or <input type="checkbox"/> nasal flaring or <input type="checkbox"/> head nodding <input type="checkbox"/> grunting
b) <input type="checkbox"/> Oxygenation	<input type="checkbox"/> central cyanosis or <input type="checkbox"/> SaO ₂ <90% (adjusted for altitude)
c) <input type="checkbox"/> Circulation	<input type="checkbox"/> Limb temperature gradient or <input type="checkbox"/> cap refill >3 seconds
d) <input type="checkbox"/> AVPU	< "A"
e) <input type="checkbox"/> Pulse	> 180 per min [_____ beats per minute]
f) <input type="checkbox"/> Hb	< 7g/dl [_____ . ____g/dl]
g) <input type="checkbox"/> WBC	< 4 or > 17.5 x 10 ⁹ /l [_____ . ____10 ⁹ /l]
h) <input type="checkbox"/> Blood glucose	< 3mmol/L [_____ . ____mmol/L]
i) <input type="checkbox"/> Documented temperature at admission or screening	<input type="checkbox"/> <36 or <input type="checkbox"/> >38.5°C
j) <input type="checkbox"/> Very low MUAC	MUAC <11cm

If eligible by 2 criteria, please continue to admission

2. ADMISSION TO HOSPITAL AND TRIAL ENROLMENT

2.1.	DATE arrived at the hospital	____/____/_____ D D / M M / Y Y Y Y
2.2.	TIME arrived at the hospital	____:____ <input type="checkbox"/> unknown 24h Clock
2.3.	Hospital IP Number (Use Serial number for Kilifi site)	_____
2.4.	Date of consent	____/____/_____ D D / M M / Y Y Y Y
2.5.	Time of consent	____:____ 24h Clock
2.6.	Consented by Initials	_____
2.7.	DATE of enrolment <i>i.e. date consented and seen by research team</i>	____/____/_____ D D / M M / Y Y Y Y
2.8.	TIME of enrolment	____:____ 24h Clock

PB-SAM Enrolment CRF v1.2



Patient Initials [][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

2.9.	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female
2.10.	DOB	____/____/_____ D D / M M / Y Y Y Y	
2.11.	Is the DOB:	<input type="checkbox"/> True	<input type="checkbox"/> Estimated*

*if DOB is estimated, and the day is uncertain, write '15' for DD

3. PRESENTING AND CURRENT COMPLAINTS

3.1.	What were the presenting complaints at admission? <i>(Select all that apply)</i>	<input type="checkbox"/> Fever / Hotness of body <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Cough <14 days <input type="checkbox"/> Diarrhoea >14 days <input type="checkbox"/> Altered consciousness <input type="checkbox"/> skin changes (fill in 3.2) <input type="checkbox"/> Hair changes (fill in 3.3) <input type="checkbox"/> Other _____	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea <14 days <input type="checkbox"/> Cough >14 days <input type="checkbox"/> Blood in stool <input type="checkbox"/> Body swelling (oedema)	<input type="checkbox"/> Lethargy <input type="checkbox"/> Convulsions <input type="checkbox"/> Poor feeding
3.2.	Skin changes (if checked at 3.1)	<input type="checkbox"/> Rash <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Hypopigmentation <input type="checkbox"/> Peeling <input type="checkbox"/> Blisters <input type="checkbox"/> Thickening of skin How long have skin changes been present ____ Days/____ Months		
3.3.	Hair Changes (if checked at 3.1)	<input type="checkbox"/> Reddened colour <input type="checkbox"/> Light colour <input type="checkbox"/> Straighter than usual <input type="checkbox"/> Thinner than usual		

4. TREATMENT FOR THIS ILLNESS

4.1.	Have you visited a hospital for this illness? <i>(Select any that apply)</i>	<input type="checkbox"/> No <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient (Overnight stay)
------	---	---

5. BIRTH HISTORY

5.1.	Birth details <i>(Select any that apply)</i>	
5.2.	Preterm (< 37 weeks)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5.3.	Born small (<2.5kg)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5.4.	Twin/multiple births	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5.5.	Born at term	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

6. ANTHROPOMETRY

6.1.	Weight <i>(to be taken using SECA scales for CHAIN study)</i>	____ . ____ kg
6.2.	Length/Height <i>(to be taken using SECA 416 infantometer provided for study)</i>	<input type="checkbox"/> Length <input type="checkbox"/> Height Measurer 1: ____ . ____ cm Measurer 2: ____ . ____ cm
6.3.	MUAC <i>(To be taken using MUAC tape for CHAIN study)</i>	Measurer 1: ____ . ____ cm Measurer 2: ____ . ____ cm
6.4.	Head circumference <i>(To be taken using CHAIN measuring tape)</i>	Measurer 1: ____ . ____ cm Measurer 2: ____ . ____ cm
6.5.	Staff Initials	Measurer 1: ____ Measurer 2: ____

PB-SAM Enrolment CRF v1.2



Patient Initials [][][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

NB: If the child is unwell the Length and Head Circumference can be taken at a later time.

7. PREVIOUS HEALTH	
7.1. Previously admitted to hospital. <i>(Includes other hospitals / health centres. Select 1)</i>	<input type="checkbox"/> No <input type="checkbox"/> < 1 week ago <input type="checkbox"/> 1 week-1month ago <input type="checkbox"/> >1month ago
7.2. Any medication last 7 days before admission. <i>(Select all that apply)</i>	<input type="checkbox"/> No medication <input type="checkbox"/> Antibiotic <input type="checkbox"/> Antimalarial <input type="checkbox"/> Traditional <input type="checkbox"/> Deworming <input type="checkbox"/> Vitamin <input type="checkbox"/> Yes, but unknown <input type="checkbox"/> Other (Specify) _____
7.3. Has the child previously had oedema (body swelling)?	<input type="checkbox"/> Y <input type="checkbox"/> N
7.4. Urine production in last 24hrs? <i>(Select 1)</i>	<input type="checkbox"/> Normal or greater <input type="checkbox"/> Less than normal <input type="checkbox"/> Not passing urine <input type="checkbox"/> Unknown

8. LONG TERM MEDICATION	
8.1 Was child on any long term medication before hospitalization? <i>(select any that apply)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, select any that apply. ARV's <input type="checkbox"/> Zidovudine/azidothymidine (ZDV/AZT) <input type="checkbox"/> Lamivudine (3TC) <input type="checkbox"/> Abacavir (ABC) <input type="checkbox"/> Nevirapine (NVP) <input type="checkbox"/> Efavirenz (EFV) <input type="checkbox"/> Lopinavir/Ritonavir (Kaletra, LPV/r) <input type="checkbox"/> Other
	Neuro <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Valproic acid <input type="checkbox"/> Levetiracetam <input type="checkbox"/> Lamotrigine <input type="checkbox"/> Other
	Sickle cell <input type="checkbox"/> Hydroxyurea <input type="checkbox"/> Other
	Anti-TBs <input type="checkbox"/> Isoniazid <input type="checkbox"/> Rifampin <input type="checkbox"/> Pyrazinamide (PZA) <input type="checkbox"/> Ethambutol <input type="checkbox"/> Other
	Long term antibiotic prophylaxis <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Penicillin



Patient Initials [][][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

9. TREATMENT GIVEN BEFORE ARRIVAL AT STUDY HOSPITAL

9.1.	Intravenous Antibiotics Given? <i>(select any that apply)</i>	<input type="checkbox"/> Not given <input type="checkbox"/> Benzylpenicillin <input type="checkbox"/> Gentamicin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Chloramphenicol <input type="checkbox"/> Ampicillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Meropenem <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Vancomycin <input type="checkbox"/> Metronidazole <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Penicillin <input type="checkbox"/> Other _____
9.2.	Oral Antibiotics Given? <i>(select any that apply)</i>	<input type="checkbox"/> Not given <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Azithromycin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Metronidazole <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Nalidixic acid <input type="checkbox"/> Penicillin <input type="checkbox"/> Flucloxacillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other _____

10. ENROLMENT VITAL SIGNS

10.1.	Axillary temperature	_____ °C
10.2.	Respiratory rate <i>(Count for 1 minute)</i>	_____/minute
10.3.	Heart rate <i>(Count for 1 minute)</i>	_____/minute
10.4.	SaO2 <i>(To be taken from finger or toe using pulse oximeter)</i>	_____ % <i>Leave blank if unrecordable</i>
10.5.	Where was SaO2 Measured?	<input type="checkbox"/> Measured on Oxygen <input type="checkbox"/> Measured in Room Air <input type="checkbox"/> Unrecordable

11. EXAMINATION

<i>Examination should be performed by CHAIN study clinician trained in clinical examination of children, and able to formulate a diagnosis based on clinical history and findings. Refer to Clinical Examination SOP</i>		
11.1.	Airway <i>(select one)</i>	<input type="checkbox"/> Clear <input type="checkbox"/> Needs active support <input type="checkbox"/> Obstructed/Stridor
11.2.	Breathing <i>(select all that apply)</i>	<input type="checkbox"/> Normal – no concerns, (move to circulation) <input type="checkbox"/> Central cyanosis <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Reduced air-entry <input type="checkbox"/> Wheeze <input type="checkbox"/> Acidotic Breathing <input type="checkbox"/> Grunting

PB-SAM Enrolment CRF v1.2



Patient Initials [][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

		<input type="checkbox"/> Lower chest wall indrawing <input type="checkbox"/> Head nodding	<input type="checkbox"/> Crackles	<input type="checkbox"/> Dull to percussion
11.3.	Circulation: a) Cap Refill (select one) b) Peripheral temperature (select one) c) Pulse Volume (select one):	<input type="checkbox"/> <2s <input type="checkbox"/> 2-3s <input type="checkbox"/> >3s	<input type="checkbox"/> Warm peripheries	<input type="checkbox"/> Cold peripheries
		<input type="checkbox"/> Normal	<input type="checkbox"/> Weak	
11.4.	Disability: a) Conscious level (select one) b) Fontanelle (select one) c) Tone (select one) d) Posture (select one) e) Activity (select one)	<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive
		<input type="checkbox"/> Normal	<input type="checkbox"/> Bulging	<input type="checkbox"/> Sunken <input type="checkbox"/> Not present
		<input type="checkbox"/> Normal	<input type="checkbox"/> Hypertonic	<input type="checkbox"/> Hypotonic
		<input type="checkbox"/> Normal	<input type="checkbox"/> Decorticate	<input type="checkbox"/> Decerebrate
		<input type="checkbox"/> Normal	<input type="checkbox"/> Irritable/Agitated	<input type="checkbox"/> Lethargic
11.5.	Dehydration: a) Sunken eyes? (Select one) b) Skin pinch (Select one)	<input type="checkbox"/> Y <input type="checkbox"/> N		
		<input type="checkbox"/> Immediate	<input type="checkbox"/> <2 seconds	<input type="checkbox"/> >2 seconds
11.6.	Oedema (select any that apply)	<input type="checkbox"/> None	<input type="checkbox"/> both feet/ankles	<input type="checkbox"/> lower legs
		<input type="checkbox"/> hands or lower arms	<input type="checkbox"/> face	
11.7.	Drinking/Breastfeeding (Select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Poorly	<input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
11.8.	Abdomen (select any that apply)	<input type="checkbox"/> Normal – no concerns	<input type="checkbox"/> Distension	<input type="checkbox"/> Hepatomegaly
		<input type="checkbox"/> Tenderness	<input type="checkbox"/> Splenomegaly	<input type="checkbox"/> Other abdominal mass
11.9.	Signs of Rickets (select any that apply)	<input type="checkbox"/> None	<input type="checkbox"/> Wrist widening	<input type="checkbox"/> Rachitic rosary
		<input type="checkbox"/> Swollen knees	<input type="checkbox"/> Bow legs	<input type="checkbox"/> Frontal bossing
11.10.	Jaundice (Select one)	<input type="checkbox"/> Y <input type="checkbox"/> N		
11.11.	ENT/Oral/Eyes (select any that apply)	<input type="checkbox"/> Mouth Normal	<input type="checkbox"/> Oral ulceration	<input type="checkbox"/> Oral candidiasis
		<input type="checkbox"/> Stomatitis		
		<input type="checkbox"/> Ears Normal	<input type="checkbox"/> Pus from ear	<input type="checkbox"/> Tender swelling behind ear (mastoiditis)
		<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Eye discharge
		<input type="checkbox"/> Eyes Normal	<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Visual impairment

PB-SAM Enrolment CRF v1.2



Patient Initials [][][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

11.12.	Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> Depigmentation
	a) Type of skin lesion (select any that apply)	<input type="checkbox"/> Broken skin <input type="checkbox"/> Cellulitis <input type="checkbox"/> Vesicles	<input type="checkbox"/> Dermatitis <input type="checkbox"/> Impetigo <input type="checkbox"/> Desquamation	<input type="checkbox"/> 'Flaky paint' <input type="checkbox"/> Pustules <input type="checkbox"/> Macular or papular
	b) Site of skin lesions. (select any that apply)	<input type="checkbox"/> Not applicable (No rash) <input type="checkbox"/> Palms / soles <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs <input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum		

12. SUSPECTED CHRONIC CONDITIONS

Select confirmed, suspected or none for all conditions:		Confirmed/Suspected (diagnosed previously/ recorded/ clinician's impression)	None
12.1.	Cerebral palsy/neurological problem/epilepsy (Select one)	<input type="checkbox"/>	<input type="checkbox"/>
12.2.	Sickle Cell disease (select one)	<input type="checkbox"/>	<input type="checkbox"/>
12.3.	Thalassaemia (Select one)	<input type="checkbox"/>	<input type="checkbox"/>
12.4.	Visual problem / Blindness (select one)	<input type="checkbox"/>	<input type="checkbox"/>

13. FEEDING PRIOR TO ADMISSION

13.1.	Prior to this admission child <u>actively attending</u> outpatient nutrition program? (Select one)	<input type="checkbox"/> Supplementary (corn soy blend, RUSF, khichuri, halwa) <input type="checkbox"/> Therapeutic (RUTF, Plumpy-nut) <input type="checkbox"/> None		
13.2.	Has the child eaten solid food in last 24 hrs (Select one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13.3.	Has child taken liquids or breastfed in last 24 hrs (Select one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13.4.	Is the child currently breastfeeding? (Select one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13.5.	Does the child usually have other feeds other than breastmilk? (Select one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13.6.	If NOT breastfeeding at all, age stopped in months? (select one)	<input type="checkbox"/> N/A (still breastfeeding) <input type="checkbox"/> 0-3m <input type="checkbox"/> 4-6m <input type="checkbox"/> 7-12m <input type="checkbox"/> >12m <input type="checkbox"/> Unknown		



Patient Initials [][][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

14. IMMEDIATE CLINICAL INVESTIGATIONS AND HIV STATUS AT ENROLMENT

14.1.	Malaria RDT? <i>(select one)</i>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done
14.2.	HIV status known?	<input type="checkbox"/> Child not previously tested, not known to be exposed <input type="checkbox"/> known PCR positive <input type="checkbox"/> antibody positive, unknown PCR status <input type="checkbox"/> known exposed, known PCR negative <i>(children under 18m with PCR result SEEN BY RESEARCH TEAM. If not seen select below and perform HIV RDT)</i> <input type="checkbox"/> child untested, but known to be HIV exposed
14.3.	a) If not known positive, HIV RDT results now? <i>(select one)</i>	<input type="checkbox"/> Reactive / positive <input type="checkbox"/> Non-Reactive / Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Declined testing <input type="checkbox"/> Testing not offered by study team <i>(e.g. culturally not sensitive)</i>
	b) If RDT results now is positive, was PCR sample sent? <i>(select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No missed <input type="checkbox"/> No referred
14.4.	Biological mother present at enrolment? <i>(select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.5.	HIV test offered to caregiver? <i>(Offer if only biological mother)</i>	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Declined <input type="checkbox"/> mother is known positive <input type="checkbox"/> Missed <input type="checkbox"/> child in care home <input type="checkbox"/> Not offered by study team <i>(e.g. culturally not sensitive)</i> <input type="checkbox"/> Mother not available



Patient Initials [][][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

15. TREATMENT IN STUDY HOSPITAL BEFORE ENROLMENT			
15.1.	Admitted to: <i>(select one)</i>	<input type="checkbox"/> Admission to ward	<input type="checkbox"/> Admission to HDU <input type="checkbox"/> Admission to ICU
15.2.	Date and time First antibiotics given	___/___/____ <i>(dd/mm/yyyy)</i>	____:____ <i>24h clock</i> <input type="checkbox"/> Not given
15.3.	Intravenous Antibiotics Given? <i>(select any that apply)</i>	<input type="checkbox"/> Not given <input type="checkbox"/> Benzylpenicillin <input type="checkbox"/> Gentamicin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Chloramphenicol <input type="checkbox"/> Ampicillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Meropenem <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Vancomycin <input type="checkbox"/> Metronidazole <input type="checkbox"/> Other _____	
15.4.	Oral Antibiotics Given? <i>(select any that apply)</i>	<input type="checkbox"/> Not given <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Azithromycin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Metronidazole <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Nalidixic acid <input type="checkbox"/> Penicillin <input type="checkbox"/> Flucloxacillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other _____	

16. SUSPECTED INITIAL DIAGNOSES:	
<i>Clinical diagnosis should be based on examination and investigation findings. Tick the <u>three most likely</u> diagnoses.</i>	
16.1.	Common Infections <i>(select any that apply)</i> <input type="checkbox"/> pneumonia <input type="checkbox"/> Severe pneumonia <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> Malaria <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> UTI <input type="checkbox"/> URTI <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Febrile illness unspecified <input type="checkbox"/> Enteric fever <input type="checkbox"/> Not applicable
16.2.	Other suspected diagnosis <i>(select any that apply)</i> <input type="checkbox"/> Anaemia <input type="checkbox"/> Adverse Drug Reaction <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Developmental delay <input type="checkbox"/> Epilepsy <input type="checkbox"/> Extra pulmonary TB <input type="checkbox"/> Failed appetite test only <input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Ileus <input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Otitis media <input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Probable meningitis

PB-SAM Enrolment CRF v1.2



Patient Initials [][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

		<input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Renal impairment <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Suspected Toxicity <input type="checkbox"/> Thalassemia <input type="checkbox"/> Varicella <input type="checkbox"/> Other, specify: _____
--	--	---

17. ADMISSION INVESTIGATIONS AND SAMPLE COLLECTION		
17.1.	CBC taken? <i>(Kilifi, Dhaka, Blantyre; As part of routine clinical care; select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.2.	Clinical chemistry taken (iSTAT) <i>(Kilifi and Dhaka; select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA (Kampala, Blantyre)
17.3.	Blood culture taken <i>(if available at site as part of routine care; select one))</i>	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> Y AFTER ABX <input type="checkbox"/> No
17.4.	EDTA 3ml blood taken (for storage) <i>(Select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No, Difficult venepuncture <input type="checkbox"/> No, Child uncooperative <input type="checkbox"/> No, Parent refused <input type="checkbox"/> No, Other
17.5.	Rectal swab taken <i>(Select one)</i>	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> Y AFTER ABX <input type="checkbox"/> No
17.6.	Date and Time Rectal swabs taken	____/____/_____ <i>DD/MM/YYYY</i> ____:____ Hrs <i>24 h clock</i>
17.7.	Stool sample taken? <i>(Must be Taken within first 48h of enrolment; select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.8.	Date and Time stool sample taken	____/____/_____ <i>DD/MM/YYYY</i> ____:____ Hrs <i>24 h clock</i>

18. SAMPLES TAKEN BY		
18.1.	Blood Samples taken by (initials)	_____
18.2.	Rectal Swabs taken by (initials)	_____
18.3.	Stool taken by (initials)	_____

PB-SAM Enrolment CRF v1.2



Patient Initials [][][][]

PB-SAM Number [3][0][][][]

Screening Number [M][][][][] (Kampala only)

19. CRF COMPLETION

19.1.	a) CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i>	_____
	b) Date	____/____/_____ D D / M M / Y Y Y Y
	c) Time	____:_____ 24 h clock
19.2	a) CRF Reviewed by (Initials)	_____
	b) Date	____/____/_____ D D / M M / Y Y Y Y
	c) Time	____:_____ 24 h clock