



Patient Initials [][][]

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

Day 21 Follow Up		
1. VISIT DETAILS		
1.1.	Date seen or contacted on phone	___/___/_____ D D / M M / Y Y Y Y
1.2.	Time seen or contacted on phone (24H Clock)	__:__:____ (24H Clock)
1.3.	Seen at	<input type="checkbox"/> Hospital / clinic <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> In Community <input type="checkbox"/> Confirmed vital status phone - alive <input type="checkbox"/> Confirmed vital status phone – dead

2. ANTHROPOMETRY		
2.1.	Weight (to be taken using SECA scales for CHAIN study)	___ . ___ kg
2.2.	Length/ height (Select ONE) (Length measured lying down if participant less than 24 months and height measured standing)	<input type="checkbox"/> Length <input type="checkbox"/> Height (to be taken using SECA 416 infantometer provided for study) Measurer 1: ___ . ___ cm Measurer 2: ___ . ___ cm
2.3.	MUAC (To be taken using MUAC tape for CHAIN study)	Measurer 1: ___ . ___ cm Measurer 2: ___ . ___ cm
2.4.	Head circumference (To be taken using CHAIN measuring tape)	Measurer 1: ___ . ___ cm Measurer 2: ___ . ___ cm
2.5.	Oedema (Select ALL 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
2.6.	Growth changes consistent with previous measurements?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available (If no, consider to be wrong measurement, child or file)
2.7.	Staff Initials	Measurer 1: _____ Measurer 2: _____



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3. HOSPITAL ADMISSIONS		
3.1.	Any admissions (e.g. overnight stay) to a hospital since discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES (Complete SAE form)</i>
	If Yes	
	a) Admission date 1: <i>(If not known estimate)</i>	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 1	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	d) Source of information 1 <i>(Select ALL that apply)</i>	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
3.2.	If Second admission	<input type="checkbox"/> Not applicable
	a) Admission date 2 <i>(If not known, estimate)</i>	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Date of discharge 2	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	e) Source of information 2 <i>(Select ALL that apply)</i>	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
3.3.	If third admission	<input type="checkbox"/> Not applicable
	a) Admission date 3 <i>(If not known, estimate)</i>	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 3	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Source of information 3 <i>(Select ALL that apply)</i>	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report



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4. CURRENT HEALTH		
4.1.	<p>What symptoms were noticed in the last 7 days? <i>If any meet criteria for Grade 3 or 4 toxicity, then a toxicity CRF must also be filled. Refer to SAE and Toxicity SOP.</i> (Select ALL that apply)</p>	<input type="checkbox"/> No symptoms, child is well <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Cough <input type="checkbox"/> Difficulties with feeding/loss of appetite <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Yellowness of skin/eyes <input type="checkbox"/> Rash / skin lesion

5. MEDICATIONS AT DAY 21		
5.1.	<p>Enzyme/Placebo: a) Bottle 1 i). Weight</p>	<p> _ _ _ grams</p> <p><input type="checkbox"/> Used completely <input type="checkbox"/> Partly Used <input type="checkbox"/> Returned as unused <input type="checkbox"/> Not Returned</p>
	<p>b) Bottle 2 i). Weight</p>	<p><input checked="" type="checkbox"/> Not applicable, only 1 bottle given</p> <p> _ _ _ grams</p> <p><input type="checkbox"/> Used completely <input type="checkbox"/> Partly Used <input type="checkbox"/> Returned as unused <input type="checkbox"/> Not Returned</p>
	<p>ii). Usage</p>	
5.2.	<p>Urso/Placebo: c) Bottle 1 i). Weight</p>	<p> _ _ _ grams</p> <p><input type="checkbox"/> Used completely <input type="checkbox"/> Partly Used <input type="checkbox"/> Returned as unused <input type="checkbox"/> Not Returned</p>
	<p>ii). Usage</p>	
	<p>d) Bottle 2 ii). Weight</p>	<p><input checked="" type="checkbox"/> Not applicable, only 1 bottle given</p> <p> _ _ _ grams</p> <p><input type="checkbox"/> Used completely <input type="checkbox"/> Partly Used <input type="checkbox"/> Returned as unused <input type="checkbox"/> Not Returned</p>
	<p>iii). Usage</p>	



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6. Outpatient Appointments		
6.1.	a) Attended Nutrition follow-up since discharge <i>(Select ONE)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. FEEDING		
7.1.	Currently in outpatient nutrition program? <i>Select one. If not in feeding program circle 'none'</i>	<input type="checkbox"/> None <input type="checkbox"/> Supplementary <input type="checkbox"/> Therapeutic <i>(corn soy blend, RUSF, (RUTF, Plumpy-nut)</i> <i>khichuri, halwa etc)</i>
7.2.	How many times attended since discharge	__ __ times
7.3.	Has the child eaten the following nutrition products in the last 3 days? (Select ALL that apply)	<input type="checkbox"/> None <input type="checkbox"/> Supplementary <input type="checkbox"/> Therapeutic

8. PLAN DAY 60 VISIT		
8.1.	Date of next visit	__/__/____ <i>D D/M M/ Y Y Y Y</i>
8.2.	Any new contact details?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, details _____



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9. D21 INVESTIGATIONS AND SAMPLE COLLECTIONS

9.1.	EDTA blood sample taken	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.2.	Date and Time EDTA blood taken	<div style="text-align: center;"> ___/___/_____ <i>D D/M M/ Y Y Y Y</i> </div> <div style="text-align: center;"> ___:___ <i>(24H Clock)</i> </div>
9.3.	If unable to take blood samples, why? (Select ONE)	<input type="checkbox"/> N/A <input type="checkbox"/> Difficult venepuncture <input type="checkbox"/> Child uncooperative <input type="checkbox"/> Parent refused <input type="checkbox"/> Other venepuncture within 12h
9.4.	a) Rectal swabs taken	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Date and Time Rectal swabs taken	<div style="text-align: center;"> ___/___/_____ <i>D D/M M/ Y Y Y Y</i> </div> <div style="text-align: center;"> ___:___ <i>(24H Clock)</i> </div>
9.5.	Stool sample taken	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.6.	Date and Time Stool taken	<div style="text-align: center;"> ___/___/_____ <i>D D/M M/ Y Y Y Y</i> </div> <div style="text-align: center;"> ___:___ <i>(24H Clock)</i> </div>
9.7.	Blood Samples taken by (initials) (Select N/A if blood sample was not collected)	<input type="checkbox"/> N/A _____
9.8.	Rectal Swabs taken by (initials) (Select N/A if rectal swab sample was not collected)	<input type="checkbox"/> N/A _____
9.9.	Stool taken by (initials) (Select N/A if stool sample was not collected)	<input type="checkbox"/> N/A _____



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10. CRF COMPLETION

10.1.	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 <i>(24 hr clock)</i>	____:____
10.2	d) CRF Reviewed by (Initials)	_____
	e) Date	____/____/_____ D D / M M / Y Y Y Y
	f) Time <i>(24 hr clock)</i>	____:____