



Patient Initials: [][][][][][]

PB-SAM Number [4][0][][][][]

Day 60 Follow Up		
1. VISIT DETAILS		
1.1.	Date seen or contacted on phone?	___ ___ / ___ ___ / ___ ___ ___ ___ <i>D D / M M / Y Y Y Y</i>
1.2.	Time seen or contacted on phone	___ : ___ 24 hour clock
1.3.	Seen at (Select ONE)	<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		
	Anthropometry done	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.1.	Weight (to be taken using SECA scales for CHAIN study)	___ ___ . ___ ___ kg
2.2.	Length or 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? (Select ONE)	<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 DAY 21?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Complete SAE form)
	If Yes	
	a) Admission date 1 (If not known, estimate)	___/___/___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 1	___/___/___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	d) Source of information 1	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
3.2.	If Second re-admission	<input type="checkbox"/> Not applicable
	a) Re-admission date 2 (If not known, estimate)	___/___/___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Date of discharge 2	___/___/___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	e) Source of information 1	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report
3.3.	If third re-admission	<input type="checkbox"/> Not applicable
	a) 3 rd Re-admission date (If not known, estimate)	___/___/___ D D / M M / Y Y Y Y
	b) Date of discharge 2	<input type="checkbox"/> Not applicable ___/___/___ D D / M M / Y Y Y Y <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Source of information 1	<input type="checkbox"/> Hospital letter or medical file <input type="checkbox"/> Parent/carer report

4. CURRENT HEALTH		
4.1.	a) What symptoms were noticed in the last 7 days? If any meet criteria for 3 or 4 toxicity, then a toxicity CRF must also be filled. Refer to SAE and Toxicity SOP. (Select all that apply)	<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



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5. FEEDING		
5.1.	Currently in outpatient nutrition program? <i>Select one. If not in feeding program circle 'none'</i>	<input type="checkbox"/> None <input type="checkbox"/> Supplementary (corn soy blend, RUSF, khichuri, halwa etc) <input type="checkbox"/> Therapeutic (RUTF, Plumpy-nut)
5.2.	Attended a Nutrition follow-up appointment d) If yes, how many times attended	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
5.3.	Has the child eaten the following nutrition products in the last 3 days?	<input type="checkbox"/> None <input type="checkbox"/> Supplementary <input type="checkbox"/> Therapeutic

6. D60 INVESTIGATIONS AND SAMPLE COLLECTIONS			
6.1	Rectal swabs taken	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date and Time taken ___/___/_____ D D/M M/ Y Y Y Y ____:____ (24H Clock)
6.2	Stool sample taken	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date and Time taken ___/___/_____ D D/M M/ Y Y Y Y ____:____ (24H Clock)
6.3	Rectal Swabs taken by (initials)	<input type="checkbox"/> N/A _____	
6.4	Stool taken by (initials)	<input type="checkbox"/> N/A _____	



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7.CRF COMPLETION

7.1	a) CRF Completed by (Initials) – to be signed when complete <i>Do not sign if any fields are empty</i>	_____
	b) Date	____/____/____ <i>D D / M M / Y Y Y Y</i>
	c) Time <i>(24 hr clock)</i>	____:____
7.2	d) CRF Reviewed by (Initials)	_____
	e) Date	____/____/____ <i>D D / M M / Y Y Y Y</i>
	f) Time <i>(24 hr clock)</i>	____:____