



Patient Initials: [][][][]

PB-SAM Number [2][0][][][][]

Day 60 Follow Up		
1. VISIT DETAILS		
1.1.	Date seen or contacted on phone?	
1.2.	Time seen or contacted on phone	24 hour clock
1.3.	Seen at (Select ONE)	☐ Hospital / clinic ☐ Hospital inpatient ☐ In Community ☐ Confirmed vital status phone - alive ☐ Confirmed vital status phone – dead

2. ANTHROPOMETRY		
	Anthropometry done	☐ Yes ☐ 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)	☐ Length ☐ 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)	☐ None ☐ both feet/ankles ☐ lower legs ☐ hands or lower arms ☐ face
2.6.	Growth changes consistent with previous measurements? (Select ONE)	☐ Yes ☐ No ☐ 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?	☐ Yes ☐ No <i>(Complete SAE form)</i>
	If Yes	
	a) Admission date 1 <i>(If not known, estimate)</i>	— — — / — — — / — — — — — D D / M M / Y Y Y Y
		☐ Definite date ☐ Estimated date
	b) Date of discharge 1	— — — / — — — / — — — — — D D / M M / Y Y Y Y
		☐ Definite date ☐ Estimated date
	d) Source of information 1	☐ Hospital letter or medical file ☐ Parent/carer report
3.2.	If Second re-admission	☐ Not applicable
	a) Re-admission date 2 <i>(If not known, estimate)</i>	— — — / — — — / — — — — — D D / M M / Y Y Y Y
		☐ Definite date ☐ Estimated date
	c) Date of discharge 2	— — — / — — — / — — — — — D D / M M / Y Y Y Y
		☐ Definite date ☐ Estimated date
	e) Source of information 1	☐ Hospital letter or medical file ☐ Parent/carer report
3.3.	If third re-admission	☐ Not applicable
	a) 3rd Re-admission date <i>(If not known, estimate)</i>	— — — / — — — / — — — — — D D / M M / Y Y Y Y
	b) Date of discharge 2	☐ Not applicable
		— — — / — — — / — — — — — D D / M M / Y Y Y Y
		☐ Definite date ☐ Estimated date
	c) Source of information 1	☐ Hospital letter or medical file ☐ Parent/carer report

4. CURRENT HEALTH

4.1.	a) What symptoms were noticed in the last 7 days? <i>If any meet criteria for 3 or 4 toxicity, then a toxicity CRF must also be filled. Refer to SAE and Toxicity SOP.</i> <i>(Select all that apply)</i>	☐ No symptoms, child is well ☐ Fever ☐ Vomiting ☐ Diarrhoea ☐ Blood in stool ☐ Cough ☐ Difficulties with feeding/loss of appetite ☐ Difficulty breathing ☐ Yellowness of skin/eyes ☐ 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>	☐ None ☐ Supplementary (corn soy blend, RUSF, khichuri, halwa etc) ☐ Therapeutic (RUTF, Plumpy-nut)
5.2.	Attended a Nutrition follow-up appointment d) If yes, how many times attended	☐ Yes ☐ No _____
5.3.	Has the child eaten the following nutrition products in the last 3 days?	☐ None ☐ Supplementary ☐ Therapeutic

6. D60 INVESTIGATIONS AND SAMPLE COLLECTIONS

6.1	Rectal swabs taken	☐ Yes ☐ No	Date and Time taken ____/____/_____ <i>D D/M M/ Y Y Y Y</i> ____:____ <i>(24H Clock)</i>
6.2	Stool sample taken	☐ Yes ☐ No	Date and Time taken ____/____/_____ <i>D D/M M/ Y Y Y Y</i> ____:____ <i>(24H Clock)</i>
6.3	Rectal Swabs taken by (initials)	☐ N/A _____	
6.4	Stool taken by (initials)	☐ 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	____/____/_____ D D / M M / Y Y Y Y
	c) Time (24 hr clock)	____:____
7.2	d) CRF Reviewed by (Initials)	_____
	e) Date	____/____/_____ D D / M M / Y Y Y Y
	f) Time (24 hr clock)	____:____