Patient Initials: [ ][ ][ ]   PB-SAM Number [3][0] [ ][ ][ ]

Day 60 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**	__ __ : __ __ 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 *(Complete SAE form)*
	If Yes a) **Admission date 1** *(If not known, estimate)*	__ __ / __ __ / __ __ __ __ *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** a) **Re-admission date 2** *(If not known, estimate)*	☐ **Not applicable** __ __ / __ __ / __ __ __ __ *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** a) **3rd Re-admission date** *(If not known, estimate)*	☐ **Not applicable** __ __ / __ __ / __ __ __ __ *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?** *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)**	☐ 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?** *Select one. If not in feeding program circle 'none'*	☐ **None**	☐ Supplementary *(corn soy blend, RUSF, khichuri, halwa etc)*	☐ Therapeutic *(RUTF, Plumpy-nut)*
5.2.	**Attended a Nutrition follow-up appointment**	☐ Yes	☐ No	
	d) **If yes, how many times attended**	_____		
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** __ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y* ___ ___ : ___ ___ *(24H Clock)*
6.2	**Stool sample taken**	☐ Yes	☐ No	**Date and Time taken** __ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y* ___ ___ : ___ ___ *(24H Clock)*
6.3	**Rectal Swabs taken by (initials)**	☐ N/A __ __ __		
6.4	**Stool taken by (initials)**	☐ N/A __ __ __		

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		7.CRF COMPLETION	Page 4 of 4
7.1	a) **CRF Completed by (Initials) – to be signed when complete** *Do not sign if any fields are empty*	__ __ __	
	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)*	___ ___ : ___ ___	