

PB SAM SCREENING FORM (YELLOW FORM)

SITE: DHAKA

SCREENING NUMBER |__|__|__|__|__|

Applicable to all children admitted to hospital with severe malnutrition. Each completed form represents one screening event.

HOSPITAL NUMBER _____ **DATE** __/__/__

	VARIABLE	VALUE/RESPONSE	MEETS CRITERIA?
INCLUSION CRITERIA			
1.	Age	__ __ months <i>(Age must be between 2 -59 months)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	MUAC	__ __ . __ cm <i>(Age > 6months <115mm; Age 2- <6 months <110mm)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	WHZ score	_____ <i><-3z scores of the median WHO growth standard</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Oedema	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Symmetrical, at least of the feet related to malnutrition)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Not mandatory if MUAC or WHZ qualifies for SAM)</i>
5.	Presence of 2 or more severity signs	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Complete severity table below</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Parent or guardian available to give consent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Severity signs *(Tick as applicable)*

	DESCRIPTION	VALUE/RESPONSE
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

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EXCLUSION CRITERIA					
	DESCRIPTION	VALUE			MEETS CRITERIA?
1.	Known congenital cardiac disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Known terminal illness e.g. cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Admission for surgery, or likely to require surgery within 6m	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Admission for trauma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Sibling enrolled in study	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Previously enrolled in this trial or currently enrolled in this trial	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Known stomach or duodenal ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Known liver disorder or exocrine pancreatic disorder – e.g. biliary atresia, history of gallstones, cystic fibrosis or clinical jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Known intolerance or allergy to any study medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Direct Bilirubin levels Above 25umol/L	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No

Summary:

1. Cumulative screening events: _____

2. Participant eligible on current screening? Yes No

(If not, consider re-assessment within 72hrs of admission. Complete a new screening form for reassessment but MAINTAIN same screening number)

3. If participant eligible, proceed to consent.