

PB SAM SCREENING FORM (YELLOW FORM)

SITE: KAMPALA

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