



Patient Initials: [][][][]

PB-SAM Number [1][0][][][]

Day 60 Follow Up		
1. VISIT DETAILS		
1.1.	Date seen or contacted on phone?	<div style="text-align: center;"> _ _ / _ _ / _ _ _ _ <i>D D / M M / Y Y Y Y</i> </div>
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		
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? (i.e. Readmission)	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Complete SAE form)</i>
	If Yes	
	a) Re-admission date 1 <i>(If not known, estimate)</i>	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 1	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <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
3.2.	If Second re-admission	<input type="checkbox"/> Not applicable
	a) Re-admission date 2 <i>(If not known, estimate)</i>	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 2	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Source of information 2	<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) Re-admission date 3 <i>(If not known, estimate)</i>	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	b) Date of discharge 3	___ / ___ / ___ <i>D D / M M / Y Y Y Y</i> <input type="checkbox"/> Definite date <input type="checkbox"/> Estimated date
	c) Source of information 3	<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? <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>	<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 (RUTF, Plumpy-nut) (corn soy blend, RUSF, khichuri, halwa etc) <input type="checkbox"/> Therapeutic
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 ___/___/_____ <i>D D/M M/ Y Y Y Y</i> ___:___ (24H Clock)
6.2	Stool sample taken	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date and Time taken ___/___/_____ <i>D D/M M/ Y Y Y Y</i> ___:___ (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>	____:____