Patient Initials: [ ][ ][ ]

PB-SAM Number [4][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**		
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?** (i.e. Readmission)	☐ Yes ☐ No *(Complete SAE form)*
	If Yes a) **Re-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
	c) 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
	b) Date of discharge 2	__ __/__ __/__ __ __ __ *D D / M M / Y Y Y Y* ☐ Definite date ☐ Estimated date
	c) Source of information 2	☐ Hospital letter or medical file ☐ Parent/carer report
3.3.	**If third re-admission** **a) Re-admission date 3** *(If not known, estimate)*	☐ **Not applicable** __ __/__ __/__ __ __ __ *D D / M M / Y Y Y Y*
	b) Date of discharge 3	☐ **Not applicable** __ __/__ __/__ __ __ __ *D D / M M / Y Y Y Y* ☐ Definite date ☐ Estimated date
	c) Source of information 3	☐ 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** **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** __ __/__ __/__ __ __ __ *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	
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)*	__ __: __ __