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

Day 21 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** *(24H Clock)*	__ __: __ __ *(24H Clock)*
1.3.	**Seen at**	☐ 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/ 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?**	☐ 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 discharge? (i.e. Readmission)**	☐ Yes ☐ No *If YES (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 *(Select ALL that apply)*	☐ Hospital letter or medical file ☐ Parent/carer report
3.2.	**If Second 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 **(Select ALL that apply)**	☐ Hospital letter or medical file ☐ Parent/carer report
3.3.	**If third 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	__ __ / __ __ / __ __ __ __ *D D / M M / Y Y Y Y* ☐ Definite date ☐ Estimated date
	c) Source of information 3 *(Select ALL that apply)*	☐ Hospital letter or medical file ☐ Parent/carer report

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CURRENT HEALTH		
3.4.	**What symptoms were noticed in the last 7 days?** *If any meet criteria for Grade 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

MEDICATIONS AT DAY 21		
3.5.	**Enzyme/Placebo:** a) Bottle 1 i). Weight ii). Usage	___ ___ ___ . ___ ___ grams ☐ Used completely ☐ Partly Used ☐ Returned as unused ☐ Not Returned
	b) Bottle 2 i). Weight ii). Usage	☐ **Not applicable, only 1 bottle given** ___ ___ ___ . ___ ___ grams ☐ Used completely ☐ Partly Used ☐ Returned as unused ☐ Not Returned
3.6.	**Urso/Placebo:** c) Bottle 1 i). Weight ii). Usage	___ ___ ___ . ___ ___ grams ☐ Used completely ☐ Partly Used ☐ Returned as unused ☐ Not Returned
	d) Bottle 2 ii). Weight iii). Usage	☐ **Not applicable, only 1 bottle given** ___ ___ ___ . ___ ___ grams ☐ Used completely ☐ Partly Used ☐ Returned as unused ☐ Not Returned

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f) Outpatient Appointments		
3.7.	a) **Attended Nutrition follow-up since discharge** *(Select ONE)*	☐ Yes ☐ No

g) FEEDING				
3.8.	**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)*
3.9.	**How many times attended since discharge**	|__ |___| times		
3.10.	**Has the child eaten the following nutrition products in the last 3 days? (Select ALL that apply)**	☐ **None**	☐ Supplementary	☐ Therapeutic

PLAN DAY 60 VISIT		
3.11.	**Date of next visit**	__ __/ __ __/ __ __ __ __ *D D/M M/ Y Y Y Y*
3.12.	**Any new contact details?**	☐ Yes ☐ No If Yes, details _____

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D21 INVESTIGATIONS AND SAMPLE COLLECTIONS		
3.13.	**EDTA blood sample taken**	☐ Yes ☐ No
3.14.	**Date and Time EDTA blood taken**	__ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y* __ __:__ __ *(24H Clock)*
3.15.	**If unable to take blood samples, why?** **(Select ONE)**	☐ Difficult venepuncture ☐ Child uncooperative ☐ Parent refused ☐ Other venepuncture within 12h
3.16.	**a) Rectal swabs taken**	☐ Yes ☐ No
	b) Date and Time Rectal swabs taken	__ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y* __ __:__ __ *(24H Clock)*
3.17.	**Stool sample taken**	☐ Yes ☐ No
3.18.	**Date and Time Stool taken**	__ __/__ __/__ __ __ __ *D D/M M/ Y Y Y Y* __ __:__ __ *(24H Clock)*
3.19.	**Blood Samples taken by (initials)** (Select N/A if blood sample was not collected)	☐N/A __ __ __
3.20.	**Rectal Swabs taken by (initials)** (Select N/A if rectal swab sample was not collected)	☐N/A __ __ __
3.21.	**Stool taken by (initials)** (Select N/A if stool sample was not collected)	☐N/A __ __ __

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CRF COMPLETION		
3.22.	**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)*	___ ___: ___ ___
10.2	d) **CRF Reviewed by (Initials)**	__ __ __
	e) Date	__ __ / __ __ / __ __ __ __ D D / M M / Y Y Y Y
	f) Time (*24 hr clock)*	___ ___: ___ ___