



Patient Initials [][][]

PB-SAM Number [][] [][][]

1. DISCHARGE DETAILS		
1.1.	Date discharged by medical team	____/____/_____ D D / M M / Y Y Y Y
1.2.	Time discharged by medical team (24H clock)	____:____ <input type="checkbox"/> Unknown
1.3.	Discharge made by clinical team?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.4.	Discharged against medical advice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.5.	Absconded?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.6.	Patient referred to other hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.7.	Discharged early because of e.g. nurses / doctors strike?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.8.	Date left hospital	____/____/_____ D D / M M / Y Y Y Y

2. STUDY MEDICATION		
2.1.	Study Medication Given?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.2.	Enzyme/Placebo a) Bottle 1: i). Weight	<input type="checkbox"/> Not given ____. ____ grams
	b) Bottle 2: i). Weight	<input type="checkbox"/> Not given ____. ____ grams
2.3.	Urso/Placebo: a) Bottle 1 i). Weight	<input type="checkbox"/> Not given ____. ____ grams
	b) Bottle 2 i). Weight	<input type="checkbox"/> Not given ____. ____ grams



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3. ANTHROPOMETRY		
3.1.	Anthropometry done?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.2.	Date anthropometry taken	___/___/_____ D D / M M / Y Y Y Y
3.3.	Weight (to be taken using SECA scales for CHAIN study)	___ . ___ kg
3.4.	Length/ 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
3.5.	MUAC (To be taken using MUAC tape for CHAIN study)	Measurer 1: ___ . ___ cm Measurer 2: ___ . ___ cm
3.6.	Head circumference (To be taken using CHAIN measuring tape)	Measurer 1: ___ . ___ cm Measurer 2: ___ . ___ cm
3.7.	Growth changes consistent with previous measurements?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, consider to be wrong measurement, child or file)
3.8.	Staff Initials	Measurer 1: _____ Measurer 2: _____

4. DISCHARGE VITALS		
4.1.	Date of vital signs	___/___/_____ D D / M M / Y Y Y Y
4.2.	Axillary temperature	___ . ___ °C
4.3.	Respiratory rate (Count for 1 minute)	___/minute
4.4.	Heart rate (Count for 1 minute)	___/minute
4.5.	SaO2 (To be taken from finger or toe using pulse oximeter)	___ % Leave blank if unrecordable
4.6.	Where was SaO2 Measured?	<input type="checkbox"/> Measured on Oxygen <input type="checkbox"/> Measured in Room Air <input type="checkbox"/> Unrecordable

If patient absconded, use vital signs collected during ward round on the day



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5. EXAMINATION	
	<i>Examination should be performed by CHAIN study clinician trained in clinical examination of children, and able to formulate a diagnosis based on clinical history and findings. Refer to Clinical Examination SOP</i>
5.1.	Airway <i>(select one)</i> <input type="checkbox"/> Clear <input type="checkbox"/> Needs active support <input type="checkbox"/> Obstructed/Stridor
5.2.	Breathing <i>(select all that apply)</i> <input type="checkbox"/> Normal – no concerns, <i>(move to circulation)</i> <input type="checkbox"/> Central cyanosis <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Reduced air-entry <input type="checkbox"/> Wheeze <input type="checkbox"/> Acidotic Breathing <input type="checkbox"/> Grunting <input type="checkbox"/> Lower chest wall indrawing <input type="checkbox"/> Crackles <input type="checkbox"/> Dull to percussion <input type="checkbox"/> Head nodding
5.3.	Circulation: a) Cap Refill <i>(select one)</i> <input type="checkbox"/> <2s <input type="checkbox"/> 2-3s <input type="checkbox"/> >3s b) Cold Peripheries <i>(select all that apply)</i> <input type="checkbox"/> Warm peripheries <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Hand c) Pulse Volume <i>(select one)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Weak
5.4.	Disability: a) Conscious level <i>(select one)</i> <input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive b) Fontanelle <i>(select one)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Not present c) Tone <i>(select one)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Hypertonic <input type="checkbox"/> Hypotonic d) Posture <i>(select one)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Decorticate <input type="checkbox"/> Decerebrate e) Activity <i>(select one)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Irritable/Agitated <input type="checkbox"/> Lethargic
5.5.	
5.6.	
5.7.	
5.8.	
5.9.	
5.10.	Dehydration: a) Sunken eyes? <i>(select one)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No b) Skin pinch <i>(select one)</i> <input type="checkbox"/> Immediate <input type="checkbox"/> <2 seconds <input type="checkbox"/> >2 seconds
5.11.	Oedema <i>(Select all that apply)</i> <input type="checkbox"/> None <input type="checkbox"/> both feet/ankles <input type="checkbox"/> lower legs <input type="checkbox"/> <input type="checkbox"/> hands or lower arms <input type="checkbox"/> face
5.12.	Drinking/Breastfeeding <i>(select one)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Poorly <input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
5.13.	Abdomen <i>(select all that apply)</i> <input type="checkbox"/> Normal – no concerns <input type="checkbox"/> Distension <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Tenderness <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Other mass
5.14.	Signs of Rickets <input type="checkbox"/> None <input type="checkbox"/> Wrist widening <input type="checkbox"/> Rachitic rosary <input type="checkbox"/> Swollen knees <input type="checkbox"/> Bow legs <input type="checkbox"/> Frontal bossing
5.15.	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No



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5.16.	ENT/Oral/Eyes <i>(select all that apply)</i>	<input type="checkbox"/> Mouth Normal <input type="checkbox"/> Oral ulceration <input type="checkbox"/> Oral candidiasis <input type="checkbox"/> Stomatitis <input type="checkbox"/> Ears Normal <input type="checkbox"/> Pus from ear <input type="checkbox"/> Tender swelling behind ear (mastoiditis) <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Eyes Normal <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Eye discharge <input type="checkbox"/> Visual impairment
5.17.	Skin a) Type of skin lesion <i>(select all that apply)</i> b) Site of skin lesions <i>(select all that apply)</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Depigmentation <input type="checkbox"/> Broken skin <input type="checkbox"/> Dermatitis <input type="checkbox"/> 'Flaky paint' <input type="checkbox"/> Cellulitis <input type="checkbox"/> Impetigo <input type="checkbox"/> Pustules <input type="checkbox"/> Vesicles <input type="checkbox"/> Desquamation <input type="checkbox"/> Macular or papular <input type="checkbox"/> Not applicable (No rash) <input type="checkbox"/> Palms / soles <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs <input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum

6. DISCHARGE DIAGNOSIS

*Clinical diagnosis should be based on examination and investigation findings.
Select up to three most likely diagnoses.*

6.1.	Common Infections <i>(select any that apply)</i>	<input type="checkbox"/> pneumonia <input type="checkbox"/> Severe pneumonia <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> Malaria <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> UTI <input type="checkbox"/> URTI <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Febrile illness unspecified <input type="checkbox"/> Enteric fever <input type="checkbox"/> Not applicable
6.2.	Other suspected diagnosis <i>(select any that apply)</i>	<input type="checkbox"/> Anaemia <input type="checkbox"/> Adverse Drug Reaction <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Developmental delay <input type="checkbox"/> Epilepsy <input type="checkbox"/> Extra pulmonary TB <input type="checkbox"/> Failed appetite test only <input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Ileus <input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Other <input type="checkbox"/> Otitis media <input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Probable meningitis <input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Renal impairment <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Suspected Toxicity <input type="checkbox"/> Thalassaemia <input type="checkbox"/> Varicella



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	Other, specify: _____
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7. FEEDING AT DISCHARGE

7.1.	At discharge is child receiving? (Select one)	<input type="checkbox"/> Supplementary (corn soy blend, RUSF, khichuri, halwa) <input type="checkbox"/> Therapeutic (RUTF, Plumpy-nut) <input type="checkbox"/> None
7.2.	Is the child completing prescribed feeds? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.3.	Is the child breastfeeding ? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. DISCHARGE TREATMENT

8.1.	a) Antibiotics at discharge? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	b) If yes IV Antibiotics as Outpatient? (Select all that apply)	<input type="checkbox"/> Penicillin <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Ampicillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> _____ Other _____	<input type="checkbox"/> Gentamicin <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Vancomycin	<input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Chloramphenicol <input type="checkbox"/> Meropenem <input type="checkbox"/> Metronidazole
	c) Oral Antibiotics (Select all that apply)	<input type="checkbox"/> Amoxicillin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Penicillin	<input type="checkbox"/> Erythromycin <input type="checkbox"/> Metronidazole <input type="checkbox"/> Co-amoxiclav <input type="checkbox"/> Flucloxacillin	<input type="checkbox"/> Azithromycin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Nalidixic acid <input type="checkbox"/> Other _____
8.2.	Other Discharge Treatment (Select all that apply)	<input type="checkbox"/> Anti-TB therapy <input type="checkbox"/> Anti-retroviral therapy (new) <input type="checkbox"/> Anti-convulsant (new) <input type="checkbox"/> Diuretic <input type="checkbox"/> Calcium <input type="checkbox"/> Antimalarial <input type="checkbox"/> None	<input type="checkbox"/> Zinc <input type="checkbox"/> Vitamin A <input type="checkbox"/> Vitamin D <input type="checkbox"/> Multivitamin <input type="checkbox"/> Iron supplement <input type="checkbox"/> Deworming <input type="checkbox"/> Other	Specify _____



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9. DISCHARGE SAMPLE COLLECTION		
9.1.	Rectal swab taken <i>(Select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.2.	Date and Time Rectal swabs taken	____/____/____ D D / M M / Y Y Y Y ____:____ 24 Hrs
9.3.	Stool sample taken <i>(Select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.4.	Date and Time Stool taken	____/____/____ D D / M M / Y Y Y Y ____:____ 24 Hrs
9.5.	Rectal Swabs taken by (initials)	____
9.6.	Stool taken by (initials)	____

10. FOLLOW UP INFORMATION		
10.1	Date of next follow up visit given to mother/ carer <i>(Select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.2	Contact information collected from mother/carers <i>(Select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.3	Is the child being discharged to same household lived in before admission? <i>(Select one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No



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11. CRF COMPLETION		
11.1.	a) CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i>	_ _ _ _
	b) Date	_ _ / _ _ / _ _ _ _ <small>D D / M M / Y Y Y Y</small>
	c) Time	_ _ : _ _ <small>24 h clock</small>
11.2.	d) CRF Reviewed by (Initials)	_ _ _ _
	e) Date	_ _ / _ _ / _ _ _ _ <small>D D / M M / Y Y Y Y</small>
	f) Time	_ _ : _ _ <small>24 h clock</small>