CHAIN Number [2][0] [0][0][1] [ ][ ][ ]

| Follow up at 90 days<br>TO BE COMPLETED WITHIN 14 DAYS OF SCHEDULED APPT<br>BY TELEPHONE IF PARTICIPANT UNABLE TO ATTEND. IF PARTICIPANT ATTENDS LATER, AMEND CRF | | | |
|---|---|---|---|
| DATE SEEN:<br>*D D / M M / Y Y Y Y* | __ __ / __ __ / __ __ __ __ | TIME SEEN: 24H Clock | __ __: __ __ |
| Seen at: | ☐ Hospital / clinic | ☐ Seen in community | ☐ Not seen |
| If not seen within 2 weeks of scheduled appointment | ☐ Confirmed alive only<br>e.g. telephoned to confirm vital status | DATE CONTACTED<br>*D D / M M / Y Y Y Y* | __ __ / __ __ / __ __ __ __ |
| | ☐ Confirmed dead<br>Complete verbal autopsy and study conclusion | DATE CONTACTED<br>*D D / M M / Y Y Y Y* | __ __ / __ __ / __ __ __ __ |
| Not seen within 2 weeks but willing to attend appointment in future<br>☐ Yes ☐ No | ☐ Unable to contact by telephone or home visit | DATE OF LAST TELEPHONE CALL<br>*D D / M M / Y Y Y Y*<br>DATE OF HOME VISIT<br>If patient did not attend and could not be reached by telephone<br>*D D / M M / Y Y Y Y* | __ __ / __ __ / __ __ __ __<br>__ __ / __ __ / __ __ __ __ |

| Anthropometry and Nutrition | | | |
|---|---|---|---|
| **Weight**<br>*to be taken using SECA scales for CHAIN* | ___ ___ . ___ ___kg | **Length** *to be taken using SECA 416 infantometer provided for CHAIN* | Measurer 1<br>____ ____. ____ cm<br>Measurer 2<br>____ ____ . ____ cm |
| **MUAC**<br>*To be taken using MUAC tape for CHAIN* | Measurer 1 ____ ____ . ____ cm<br>Measurer 2 ____ ____ . ____ cm | **Head circumference**<br>*To be taken using CHAIN measuring tape* | Measurer 1<br>____ ____. _____cm<br>Measurer 2<br>____ ____. _____cm |

CHAIN Number [2][0] [0][0][1] [ ][ ][ ]

| **Oedema** | ☐ None ☐ + ☐ ++ ☐ +++ | **Initials** | Measurer 1 ___ ___ __ | Measurer 2 ___ ___ __ |
|---|---|---|---|---|

## Current Health

| **Child in usual state of health now?** | Y N | **If No, length of current illness** | Number of days: _____ _____ |
|---|---|---|---|

**What symptoms are present now?**
*Select up to 3:*

☐**No symptoms, child is well**

| | | |
|---|---|---|
| ☐Vomiting | ☐ Fever / Hotness of body | ☐ Lethargy |
| ☐Diarrhoea <14 days | ☐ Difficulty breathing | ☐ Convulsions |
| ☐Diarrhoea >14 days | ☐ Cough<14 days | ☐ Altered consciousness |
| ☐Blood in stool | ☐ Cough>14days | ☐ Not feeding |
| ☐ Poor feeding / weight loss | ☐ Body swelling/ oedema | ☐Rash / skin lesion |

| | | | | | |
|---|---|---|---|---|---|
| **Medication last 7 days.** *Circle any that apply* | ☐ No medication | ☐·Antibiotic | ☐ Antimalarial | ☐Deworming | ☐ Multivitamin |
| | ☐ Zinc | ☐Iron supplement | ☐ Vitamin D/ Calcium | ☐ Traditional / herbal / homeopathy | ☐ Paracetamol/ Ibuprofen |
| | ☐ ORS | ☐ Antihistamine | | ☐ Yes, but unknown | |

| **HOSPITAL ADMISSIONS** | | | |
|---|---|---|---|
| Any admissions (e.g. overnight stay) to a hospital since discharge? | | | ☐Yes ☐ No ☐ Unknown |
| If Yes: **Admission date (estimate)** | **Hospital Name** | **Length of stay (days)** | **Source of information** |

CHAIN Number [2][0] [0][0][1] [ ][ ][ ]

| | | | |
|---|---|---|---|
| __ __/__ __/__ __ __ __<br>*D D / M M / Y Y Y Y* | | __ __ | ☐ Hospital letter or medical file<br>☐ Parent/carer report |
| __ __/__ __/__ __ __ __<br>*D D / M M / Y Y Y Y* | | __ __ | ☐ Hospital letter or medical file<br>☐ Parent/carer report |

| Outpatient Appointments | | |
|---|---|---|
| Participant attended outpatient appointment since discharge? | | |
| Nutrition follow-up only | Y | N |
| General paediatric appointment | Y | N |
| Cardiology appointment | Y | N |
| Neurology appointment | Y | N |
| HIV clinic | Y | N |
| TB clinic | Y | N |
| Sickle cell or thalassaemia clinic | Y | N |
| Outpatient blood transfusion | Y | N |
| Specialist Radiology | Y | N |
| Other specialist paediatric appointment | Y | N |

| Caregiver Appointments / Admissions | | |
|---|---|---|
| ☐ No outpatient appointment | ☐ Not applicable – child in care | |
| Caregiver admitted to hospital since last appointment? | Y | N |
| Psychiatry follow-up | Y | N |
| Antenatal care | Y | N |

CHAIN Number [2][0] [0][0][1] [ ][ ][ ]

| | | |
|---|---|---|
| HIV clinic | Y | N |
| TB clinic | Y | N |
| Other | Y | N |

| **Feeding** | | | |
|---|---|---|---|
| **Currently in outpatient nutrition program?** *Select one. If not in feeding program circle 'none'* | ☐ Supplementary *(corn soy blend, RUSF, khichuri, halwa etc)* | ☐ Therapeutic *(RUTF, Plumpy-nut)* | ☐ None |
| **Has the child eaten these nutrition products in the last 3 days?** | ☐ Supplementary | ☐ Therapeutic | ☐ None |
| **Currently Breastfeeding?** ☐ Y ☐ N | **If yes, taking other foods/fluids?** | ☐ Y ☐ N | |
| **If NO breastfeeding at all, age stopped (in months)?** *Select one* | ☐ 0-3m ❑ 4-6m ☐ 7-12m | ☐ >12m | ☐ Unknown |

| **Vaccinations –** *Ask carer or check book / card if available* | | | | | |
|---|---|---|---|---|---|
| **BCG scar** | ☐ Yes ☐ No | **Rotavirus** | ☐ Book | ☐ Self report ☐ Not received | **Doses received:** 3 2 1 ☐ Unknown |
| **Measles** | ☐ Book ☐ Self report ☐ Not received ☐ Unknown | **Pneumococcus** | ☐ Book | ☐ Self report ☐ Not received | **Doses received:** 3 2 1 ☐ Unknown |
| | | **DTP/Penta** | ☐ Book | ☐ Self report ☐ Not received | **Doses received:** 3 2 1 ☐ Unknown |
| | | **Polio** | ☐ Book | ☐ Self report ☐ Not received | ☐ **Unknown** |

CHAIN Number [2][0] [0][0][1] [ ][ ][ ]

| TB Screening | | | |
|---|---|---|---|
| Known TB (on treatment)<br>Y N | Child has cough >14 days<br>Y N | Household contact has TB, or cough >14 days<br>Y N | Child has suspected extrapulmonary TB<br>Y N |

## Plan day 180 Follow Up Date

__ __ / __ __ / __ __ __ __

*D D / M M / Y Y Y*

| | | | |
|---|---|---|---|
| **CRF Completed by (Initials) – to be signed when complete.**<br>*Do not sign if any fields are empty* | __ __ __ | Date<br>__ __ / __ __ / __ __ __ __<br>*D D / M M / Y Y Y Y* | Time<br>__ __ : __ __ |