



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

Eligibility Checklist		
Age between 7 days and 59 days after date of birth	Y	N - ineligible
Being admitted to hospital because of acute illness	Y	N- ineligible
Parent or guardian able and available to consent	Y	N- ineligible
Able to feed orally in usual state of health	Y	N- ineligible
Known congenital syndrome	Y- ineligible	N
Cleft palate	Y- ineligible	N
Known congenital cardiac disease	Y- ineligible	N
Known terminal illness e.g. cancer	Y- ineligible	N
Admission for surgery, or likely to require surgery within 6m	Y- ineligible	N
Admission for trauma?	Y- ineligible	N
Sibling enrolled in study	Y- ineligible	N
Previously enrolled	Y- ineligible	N

Part 1

1. Admission to Hospital and Study Enrolment

DATE arrived at the hospital	__ / __ / __ D D / M M / Y Y Y Y	TIME arrived at the hospital	__ : __ 24h Clock	<input type="checkbox"/> Arrival time unknown	
DATE of enrolment i.e. date consented and seen by research team	__ / __ / __ D D / M M / Y Y Y Y	TIME of enrolment	__ : __ 24h Clock	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
DOB	__ / __ / __ D D / M M / Y Y Y Y	Is the DOB:	<input type="checkbox"/> True <input type="checkbox"/> Estimated*	Child's Initials	__ __
Brought into hospital by: <i>Select all that apply</i>	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle	
	<input type="checkbox"/> Sibling <18	<input type="checkbox"/> Sibling >18	<input type="checkbox"/> Carer (care home)	<input type="checkbox"/> Other _____	

*if DOB is estimated, and the day is uncertain, write '15' for DD

2. Presenting Complaints

<input type="checkbox"/> Fever / Hotness of body	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Lethargy
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Diarrhoea <14 days	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Cough<14 days	<input type="checkbox"/> Diarrhoea >14 days	<input type="checkbox"/> Altered consciousness
<input type="checkbox"/> Cough>14days	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Not feeding
<input type="checkbox"/> Poor feeding/ Weight loss	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Body swelling / limb swelling/ Oedema
<input type="checkbox"/> Rash/ skin lesion	<input type="checkbox"/> Neonatal jaundice	<input type="checkbox"/> Umbilical infection
<input type="checkbox"/> Other (only one complaint, if not covered by above options)		



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3. Initial Observations (to be taken at time of examination by research team)

Axillary temperature	_____. ____ °C	Respiratory rate Count for 1 minute	_____/minute
Heart rate Count for 1 minute	_____/minute		
SaO2 To be taken from finger or toe using pulse oximeter	_____ % <input type="checkbox"/> Measured in _____ <input type="checkbox"/> Measured in _____ <input type="checkbox"/> Unrecordable Write 000 if unrecordable Oxygen Room Air		

4. Anthropometry

Weight to be taken using SECA scales for CHAIN study	_____. ____ kg		Length to be taken using SECA 416 infantometer provided for CHAIN study	Measurer 1	_____. ____ cm
				Measurer 2	_____. ____ cm
MUAC To be taken using MUAC tape for CHAIN study	Measurer 1	_____. ____ cm	Head circumference To be taken using CHAIN measuring tape	Measurer 1	_____. ____ cm
	Measurer 2	_____. ____ cm		Measurer 2	_____. ____ cm
Oedema	<input type="checkbox"/> <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++ None		Initials	Measurer 1: _____ Measurer 2: _____	

NB: If the child is unwell the Length can be taken at a later time.

5. Current Health

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Previously admitted to hospital. <i>Include other hospitals / health centres. Select 1</i>	<input type="checkbox"/> No <input type="checkbox"/> < 1 week ago <input type="checkbox"/> 1 weeks-1month ago <input type="checkbox"/> >1month ago
Any medication last 7 days. <i>Select all that apply</i>	<input type="checkbox"/> No medication <input type="checkbox"/> Antibiotic <input type="checkbox"/> Antimalarial <input type="checkbox"/> Traditional <input type="checkbox"/> Deworming <input type="checkbox"/> Vitamin <input type="checkbox"/> Paracetamol or Ibuprofen <input type="checkbox"/> Yes, but unknown <input type="checkbox"/> Other
Urine volume in last 24hrs? <i>Select 1</i>	<input type="checkbox"/> Not passing urine <input type="checkbox"/> Less than normal <input type="checkbox"/> Normal or greater <input type="checkbox"/> Unknown

6. Examination

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

Airway (select one)	<input type="checkbox"/> Clear <input type="checkbox"/> Needs active support <input type="checkbox"/> Obstructed/Stridor			
Breathing (select all that apply)	<input type="checkbox"/> Normal – no concerns , (move to circulation) <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			
Circulation:				
Cap Refill (select one)	<input type="checkbox"/> >3s	<input type="checkbox"/> 2-3s	<input type="checkbox"/> <2s	
Cold Peripheries (select one)	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hand	<input type="checkbox"/> Warm peripheries
Disability:				
Conscious level (select one)	<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive
Fontanelle (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Bulging	<input type="checkbox"/> Sunken	<input type="checkbox"/> Not present
Tone (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Hypertonic	<input type="checkbox"/> Hypotonic	
Posture (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Decorticate	<input type="checkbox"/> Decerebrate	
Activity (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Irritable/Agitated	<input type="checkbox"/> Lethargic	
Dehydration:				
Sunken eyes? Skin pinch (select one)	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> >2 seconds	<input type="checkbox"/> <2 seconds	<input type="checkbox"/> Immediate	
Drinking/Breastfeeding (Select one)	<input type="checkbox"/> Normal <input type="checkbox"/> Poorly <input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty			
Abdomen (select any that apply)	<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 abdominal mass			
Signs of Rickets	<input type="checkbox"/> Wrist <input type="checkbox"/> Rachitic <input type="checkbox"/> Swollen <input type="checkbox"/> Bow <input type="checkbox"/> Frontal <input type="checkbox"/> None <div> <div>widening</div> <div>rosary</div> <div>knees</div> <div>legs</div> <div>bossing</div> </div>			
Jaundice (Select one)	<input type="checkbox"/> Not jaundiced <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++			



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ENT/Oral/Eyes <i>(select any that apply)</i>	<input type="checkbox"/> Mouth Normal <input type="checkbox"/> Ears Normal <input type="checkbox"/> Eyes Normal <input type="checkbox"/> Oral ulceration <input type="checkbox"/> Pus from ear <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Oral candidiasis <input type="checkbox"/> Tender swelling behind ear (mastoiditis) <input type="checkbox"/> Eye discharge <input type="checkbox"/> Stomatitis <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Visual impairment
Skin <i>(select any that apply)</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Depigmentation <input type="checkbox"/> Broken <input type="checkbox"/> Dermatitis <input type="checkbox"/> 'Flaky paint' skin/excoriation <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
Site of skin lesions. <i>(select any that apply)</i>	<input type="checkbox"/> Not applicable <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs (No rash) <input type="checkbox"/> Palms / soles <input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum

7. Suspected Chronic Conditions

Select confirmed, suspected or none for all conditions:	Confirmed (diagnosed previously/ recorded)	Suspected (clinician's impression)	None
Cerebral palsy/neurological problem/ epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell disease <i>family history, crisis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thalassaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual problem / Blindness <i>Not fixing and following</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losing weight or not gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Feeding

Currently Breastfeeding?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes is the child taking anything else (exclude medicine)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
What did the child receive other than breast milk in the first 3 days of life? <i>Select all that apply</i> <i>Do not include medications e.g. ARV.</i>	<input type="checkbox"/> Sweetened/sugar water <input type="checkbox"/> Fruit Juice <input type="checkbox"/> Water <input type="checkbox"/> Pure Honey	<input type="checkbox"/> Formula/powder milk <input type="checkbox"/> Tea <input type="checkbox"/> Porridge/pulp <input type="checkbox"/> Glycerine	<input type="checkbox"/> Animal milk <input type="checkbox"/> Other <input type="checkbox"/> Gutthi / gripe water <input type="checkbox"/> Nothing



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11. Immediate Clinical Investigations and HIV status

Malaria RDT <i>circle result</i>		Positive	Negative	Not done
Blood glucose		_____ . _____ mmol/L	Time glucose measured	_____ : _____ 24h clock <input type="checkbox"/> Unknown
HIV status known?		<input type="checkbox"/> Yes, known exposed, known PCR negative (children <input type="checkbox"/> Yes, known <input type="checkbox"/> Yes, antibody positive, under 18m with PCR result SEEN BY RESEARCH TEAM. If PCR positive unknown PCR status not seen select below and perform HIV RDT <input type="checkbox"/> No, known to be HIV exposed, but child untested <input type="checkbox"/> No, child not tested, not known to be exposed		
If child known HIV positive or exposed	On any ART?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown If on treatment, ARV 1 _____ ARV 2 _____ ARV 3 _____		If on prophylaxis <input type="checkbox"/> Nevirapine prophylaxis only <input type="checkbox"/> AZT + NVP prophylaxis <input type="checkbox"/> Caregiver unsure
	Co- trimoxazole <i>select one</i>	<input type="checkbox"/> On prophylactic dose co-trimoxazole <input type="checkbox"/> On high dose <input type="checkbox"/> Not on coco-trimoxazole <input type="checkbox"/> Caregiver unsure trimoxazole		
If not known positive	HIV RDT now <i>select one</i>	<input type="checkbox"/> Reactive / positive <input type="checkbox"/> Non-Reactive / Negative <input type="checkbox"/> Declined PCR sent: <input type="checkbox"/> Y <input type="checkbox"/> N		
Referred to HIV clinic		<input type="checkbox"/> Yes <input type="checkbox"/> No (select 'No' if referral not indicated)		
HIV test offered to caregiver?		<input type="checkbox"/> Yes, <input type="checkbox"/> Yes, Reactive Non-reactive <input type="checkbox"/> Yes, but <input type="checkbox"/> No, Declined Caregiver is known positive <input type="checkbox"/> N/A child <input type="checkbox"/> Missed in care home		
Did the mother have interventions or medication during delivery to prevent transmission of HIV to baby?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Birth and perinatal care

Born in THIS hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not born in hospital <input type="checkbox"/> Unknown
Stayed more than one night in hospital after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A



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Risk factors for complications	<input type="checkbox"/> None known <input type="checkbox"/> Fever / unwell in labour <input type="checkbox"/> Membranes ruptured >24h before birth <input type="checkbox"/> Offensive liquor/vaginal discharge	<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Breech presentation <input type="checkbox"/> Premature labour <input type="checkbox"/> Unknown
Mother received medication during labour and delivery? <i>Select all that apply</i>	<input type="checkbox"/> No medication <input type="checkbox"/> General anaesthetic <input type="checkbox"/> Steroid (premature labour) <input type="checkbox"/> Traditional/herbal/ homeopathy <input type="checkbox"/> Misoprostol / induction of labour <input type="checkbox"/> Oxytocin <input type="checkbox"/> Other	<input type="checkbox"/> Unknown <input type="checkbox"/> IV antibiotic <input type="checkbox"/> Epidural /spinal <input type="checkbox"/> PMTCT <input type="checkbox"/> Analgesia <input type="checkbox"/> Antacid <input type="checkbox"/> Yes but unknown

Antenatal care received

Source of information <i>Select all that apply</i>	<input type="checkbox"/> None <input type="checkbox"/> Maternal recall <input type="checkbox"/> Health record book <input type="checkbox"/> Other relative recall
Antenatal care received? <i>Select one</i> <i>Antenatal appointment includes any scheduled at health centre, visits in the community or organised privately. These must be for pregnancy not other medical issues</i>	<input type="checkbox"/> No antenatal care <input type="checkbox"/> At least 1 antenatal appointment <input type="checkbox"/> 2 antenatal appointments <input type="checkbox"/> More than 2 appointments <input type="checkbox"/> Unknown
Ultrasound scan? <i>Select one</i>	<input type="checkbox"/> None <input type="checkbox"/> At least one <input type="checkbox"/> More than one <input type="checkbox"/> Unknown
Medication / Supplements in pregnancy <i>Select all that apply</i>	<input type="checkbox"/> None given <div> <input type="checkbox"/> Folic acid <input type="checkbox"/> Iron <input type="checkbox"/> Antiretrovirals <input type="checkbox"/> Cotrimoxazole/ septrin <input type="checkbox"/> Antibiotic <input type="checkbox"/> Magnesium sulphate <input type="checkbox"/> Supplementary food <input type="checkbox"/> Traditional / herbal/homeopathy <input type="checkbox"/> Malaria prophylaxis <input type="checkbox"/> Steroid <input type="checkbox"/> Malaria treatment <input type="checkbox"/> Yes but unknown <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other </div>
Antenatal blood screening	<input type="checkbox"/> No antenatal blood screening <input type="checkbox"/> Blood taken, reason unknown <input type="checkbox"/> Unknown if done <input type="checkbox"/> VDRL positive <input type="checkbox"/> VDRL negative <input type="checkbox"/> VDRL not done <input type="checkbox"/> Unknown <input type="checkbox"/> Hep B positive <input type="checkbox"/> Hep B negative <input type="checkbox"/> Hep B not done <input type="checkbox"/> Unknown <input type="checkbox"/> HIV positive <input type="checkbox"/> HIV negative <input type="checkbox"/> HIV not done <input type="checkbox"/> Unknown <input type="checkbox"/> Blood group done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Estimated gestation	<input type="checkbox"/> < 36 weeks <input type="checkbox"/> 36-42 weeks <input type="checkbox"/> >42 weeks <input type="checkbox"/> unknown



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Mother received blood transfusion during or after birth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Baby admitted to neonatal unit? <i>Select all that apply</i>	<input type="checkbox"/> Not admitted <input type="checkbox"/> No, admitted postnatal ward <input type="checkbox"/> Yes for respiratory support (including Oxygen) <input type="checkbox"/> Yes for antibiotics <input type="checkbox"/> Yes for IV fluids / hypoglycaemia <input type="checkbox"/> Yes for jaundice <input type="checkbox"/> Yes for transfusion <input type="checkbox"/> Yes other <input type="checkbox"/> Unknown
Baby passed stool within 24h of birth <i>(including meconium during delivery)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Is weight > birthweight now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>(if birthweight is unknown but baby now weighs >4.5kg select 'yes')</i>

Feeding and lactation support

Baby breast fed within 12h of birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Age at first breast feed	<input type="checkbox"/> <=1h <input type="checkbox"/> 1-4h <input type="checkbox"/> >4-12h <input type="checkbox"/> >12h <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown
Breast feeding at all now? <i>If mother intends to breastfeed but baby unwell select yes</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
YES breastfeeding now If not exclusively breast feeding, why? <i>Ask what else the mother is giving the baby. If giving other food/milk ask why</i>	<input type="checkbox"/> Not applicable (exclusively breastfeeding) <input type="checkbox"/> Not enough milk <input type="checkbox"/> Baby struggled to breastfeed <input type="checkbox"/> Mother unwell <input type="checkbox"/> Unknown <input type="checkbox"/> Other



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Does the mother have any help with breast feeding? <i>Select all that apply. 'Relative' refers to relative of the child. Ask the mother if she feels there is active and positive support of breast feeding</i>	<input type="checkbox"/> No support with breast feeding <input type="checkbox"/> Yes maternal relative <input type="checkbox"/> Yes paternal relative <input type="checkbox"/> Yes father <input type="checkbox"/> Yes midwife/ community health worker <input type="checkbox"/> Yes other
Does the mother/caregiver intend to continue breast feeding once the baby is over 6m old?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
NO, Not breastfeeding at all now (if mother not intending to breastfeed) Has the child ever breast fed since birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Why has breastfeeding stopped? <i>Select one, the main reason</i>	<input type="checkbox"/> Mother HIV positive <input type="checkbox"/> Not enough milk <input type="checkbox"/> Baby struggled to breastfeed <input type="checkbox"/> Mother unwell <input type="checkbox"/> Mother died, not present <input type="checkbox"/> Other
Does the mother have any help with feeding? <i>Select all that apply. 'Relative' refers to relative of the child.</i>	<input type="checkbox"/> No support with feeding <input type="checkbox"/> Yes maternal relative <input type="checkbox"/> Yes paternal relative <input type="checkbox"/> Yes father <input type="checkbox"/> Yes midwife/ community health worker <input type="checkbox"/> Yes other
Does the mother/caregiver have any help with the baby? <i>Select all that apply. 'Relative' refers to relative of the child</i>	<input type="checkbox"/> No help <input type="checkbox"/> Yes maternal relative
	<input type="checkbox"/> Yes paternal relative <input type="checkbox"/> Yes father <input type="checkbox"/> Yes midwife /community health worker <input type="checkbox"/> Yes other
Does the caregiver buy other sources of milk for the baby? <i>Select all that apply</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes infant formula <input type="checkbox"/> Yes other breast milk <input type="checkbox"/> Yes cows milk <input type="checkbox"/> Yes other
Was the mother working prior to giving birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Is the mother working now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Maternity pay?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

11. Suspected Initial Diagnoses:

c Clinical diagnosis should be based on examination and investigation findings.

Tick the three most likely diagnoses.

Respiratory	Infection	CNS
<input type="checkbox"/> LRTI/pneumonia	<input type="checkbox"/> Gastroenteritis	<input type="checkbox"/> Febrile convulsions
<input type="checkbox"/> Bronchiolitis	<input type="checkbox"/> Sepsis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> URTI	<input type="checkbox"/> Malaria	<input type="checkbox"/> Probable meningitis



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<input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Otitis media <input type="checkbox"/> Asthma General <input type="checkbox"/> Anaemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Thalassaemia <input type="checkbox"/> Renal impairment <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Nephritis <input type="checkbox"/> Liver dysfunction <input type="checkbox"/> Ileus <input type="checkbox"/> Congenital cardiac disease <input type="checkbox"/> Haemolytic disease newborn <input type="checkbox"/> Neonatal jaundice	<input type="checkbox"/> Extra pulmonary TB <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> UTI <input type="checkbox"/> HIV related illness <input type="checkbox"/> Measles <input type="checkbox"/> Varicella <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Febrile illness unspecified <input type="checkbox"/> Enteric fever <input type="checkbox"/> Infected umbilicus	<input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Developmental delay <input type="checkbox"/> Cerebral palsy / Birth asphyxia Other suspected diagnosis: <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Failed appetite test only <input type="checkbox"/> Breast-feeding difficulty <input type="checkbox"/> Tongue tie <input type="checkbox"/> Congenital syphilis <input type="checkbox"/> Microcephaly
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12 Initial Treatment				
Admitted to: <i>select one</i>	<input type="checkbox"/> Admission to ward	<input type="checkbox"/> Admission to HDU	<input type="checkbox"/> Admission to ICU	<input type="checkbox"/> Admission to neonatal unit
Date and time First antibiotics given	<div> <input type="checkbox"/> Not given </div> <div> ____ / ____ / ____ : ____ </div>			
Intravenous Antibiotics Given? <input type="checkbox"/> Not given	<div> <input type="checkbox"/> Benzylpenicillin <input type="checkbox"/> Gentamicin <input type="checkbox"/> Ceftriaxone / Cefotaxime </div> <div> <input type="checkbox"/> Co-amoxiclav / <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Chloramphenicol Augmentin </div> <div> <input type="checkbox"/> Ampicillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Meropenem / Imipenem </div> <div> <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Vancomycin <input type="checkbox"/> Metronidazole </div> <div> <input type="checkbox"/> Ceftazidime <input type="checkbox"/> Pivmecillinam </div> <div> <input type="checkbox"/> Other _____ </div>			

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Oral Antibiotics Given?	<input type="checkbox"/> Amoxicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Azithromycin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Metronidazole <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Co-amoxiclav / <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Nalidixic acid Augmentin <input type="checkbox"/> Penicillin <input type="checkbox"/> Flucloxacillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other _____	
Initial treatment given <i>First 6 hours.</i> <i>Select any that apply.</i>	<input type="checkbox"/> IV Fluid Bolus <input type="checkbox"/> Oxygen <input type="checkbox"/> IV Glucose <input type="checkbox"/> Oral Glucose <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Phenobarbitone <input type="checkbox"/> Diazepam <input type="checkbox"/> Paracetamol <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Diclofenac <input type="checkbox"/> Salbutamol / atrovent / other bronchodilator <input type="checkbox"/> Prednisolone/ dexamethasone/ hydrocortisone <input type="checkbox"/> Adrenaline <input type="checkbox"/> Zinc <input type="checkbox"/> Folic acid <input type="checkbox"/> Antimalarial (any) <input type="checkbox"/> ReSoMal <input type="checkbox"/> ORS	<input type="checkbox"/> IV Maintenance Fluids <input type="checkbox"/> CPAP <input type="checkbox"/> Warmth (heater, warmed fluids) <input type="checkbox"/> Commercial F75 <input type="checkbox"/> Commercial F100 <input type="checkbox"/> Locally prepared F75/ milk suji <input type="checkbox"/> Local prepared F100 / milk suji 100 <input type="checkbox"/> Expressed breast milk <input type="checkbox"/> Dilute F100/ dilute milk or formula <input type="checkbox"/> Other milk/ formula/ feed <input type="checkbox"/> RUTF <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Multivitamin <input type="checkbox"/> Micronutrients <input type="checkbox"/> Vitamin A <input type="checkbox"/> Albendazole / deworming <input type="checkbox"/> Other _____



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11. Admission Core Cohort Investigations and Sample Collection

CBC taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Plain Blood (serum)	<input type="checkbox"/> Y <input type="checkbox"/> N
Clinical chemistry taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood spot taken	<input type="checkbox"/> Y <input type="checkbox"/> N
EDTA 2ml blood taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood culture taken (if available at site)	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> N <input type="checkbox"/> Y AFTER ABX
EDTA 0.5ml blood taken	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood gas taken (if available at site)	<input type="checkbox"/> Capillary <input type="checkbox"/> N <input type="checkbox"/> Venous
Date Taken	Date taken _____ Time taken _____: _____ D D / M M / Y Y Y Y		
Unable to take blood samples, why?	<input type="checkbox"/> Difficult venepuncture <input type="checkbox"/> Child uncooperative <input type="checkbox"/> Parent refused <input type="checkbox"/> Other		
Rectal swabs taken	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> N <input type="checkbox"/> 1 <input type="checkbox"/> 2 Number taken _____ <input type="checkbox"/> Y AFTER ABX Time taken _____: _____		
Stool sample	Taken _____ Date taken _____ in <input type="checkbox"/> Y <input type="checkbox"/> N _____ / _____ / _____ first _____ Time taken _____: _____ 24h? D D / M M / Y Y Y Y		

Chest x-ray indicated (respiratory signs symptoms)	<input type="checkbox"/> Yes, but too unwell <input type="checkbox"/> Yes, done <input type="checkbox"/> Indicated but not done, unclear <input type="checkbox"/> Not indicated
Lumbar puncture indicated (signs of meningitis documented)	<input type="checkbox"/> Yes, but too unwell <input type="checkbox"/> Yes, done <input type="checkbox"/> Not indicated

Blood Samples taken by (initials)	_____
Rectal Swabs taken by (initials)	_____

CRF Completed by (Initials) – to be signed when complete. Do not sign if any fields are empty	_____	Date _____ / _____ / _____ D D / M M / Y Y Y Y	Time _____: _____
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PART 2**12. CHAIN ADMISSION CRF: SOCIAL INFORMATION.**



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To be completed within 48h of admission when child is stable. This should ideally be done in a conversational and unhurried way, with the interviewer sitting with the caregiver.

Initials of person interviewing caregiver and completing part 2 ____		Date ____/____/____ D D / M M / Y Y Y Y
<input type="checkbox"/> Doctor <input type="checkbox"/> Clinical officer <input type="checkbox"/> Nurse <input type="checkbox"/> Field worker <input type="checkbox"/> Research Assistant <input type="checkbox"/> Other		Time ____:____
Who is being interviewed?		
<input type="checkbox"/> Primary caregiver only <input type="checkbox"/> Care home staff <input type="checkbox"/> Primary caregiver and one other person <input type="checkbox"/> Primary caregiver and more than one other person <input type="checkbox"/> One person who is not the primary caregiver <input type="checkbox"/> More than one person who is not the primary caregiver		

13. Care-seeking Behaviour	
Was the child in generally good health before this illness?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
If No, how long has the child had this problem of generally bad health?	____ weeks <input type="checkbox"/> N/A
Does the child have health insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
What was the main reason for bringing the child to this hospital today? <i>Reasons given, select one</i>	
<input type="checkbox"/> Referred by health care worker to hospital <input type="checkbox"/> Caregiver concern of child's condition (e.g. from family, neighbour, paid work)? <input type="checkbox"/> Received money for transport <input type="checkbox"/> Relative / neighbour concern working away <input type="checkbox"/> Primary caregiver returned home e.g. if <input type="checkbox"/> Other of child's condition	
How did you travel to the hospital? <i>Select all that apply</i>	
<input type="checkbox"/> Car/ Taxi <input type="checkbox"/> Ambulance <input type="checkbox"/> Bus <input type="checkbox"/> Motorbike <input type="checkbox"/> Tuk-tuk /CNG <input type="checkbox"/> Cycle rickshaw <input type="checkbox"/> Train <input type="checkbox"/> Walking <input type="checkbox"/> Other	
How long did it take you to travel to hospital?	<input type="checkbox"/> <1h <input type="checkbox"/> 1- < 2h <input type="checkbox"/> 2-4h <input type="checkbox"/> >4h <input type="checkbox"/> > 1 day
How much did it cost the family to travel to hospital today (in local currency)? <i>Estimate amount. If walked, drove own car or free ambulance write</i>	____
Have you sought treatment for this illness prior to coming to hospital? <i>Select all that apply</i>	
<input type="checkbox"/> No treatment sought <input type="checkbox"/> Shop <input type="checkbox"/> Government hospital <input type="checkbox"/> Government dispensary <input type="checkbox"/> Traditional Healer <input type="checkbox"/> Pharmacy <input type="checkbox"/> Private Medical Facility/ NGO <input type="checkbox"/> Herbalist <input type="checkbox"/> Homeopathist <input type="checkbox"/> Other	
Received treatment from traditional healer, homeopathist or herbalist in last 4 weeks?	Y N
14. Child's Health Status Before Admission	
Before this illness, how did this child's health compare to other children of similar age in your neighbourhood? <i>Select one</i>	
<input type="checkbox"/> Similar <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Don't know	



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Before this illness, how did this child's health compare to his/her siblings at a similar age? <i>Select one</i>				
<input type="checkbox"/> Similar	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Don't know	<input type="checkbox"/> N/A only child

11. Primary Caregiver Information				
<i>This is the person who has responsibility for day to day care of the child, but is not a substitute carer such as childminder or grandparent who cares for child whilst, for example, mother is at work.</i>				
Who is the Primary Caregiver? <i>Select one</i>	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt / Uncle / Cousin <input type="checkbox"/> Stepmother / father <input type="checkbox"/> Care home / orphanage <input type="checkbox"/> Other/ Unclear			
Is the child's biological father alive?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	Is the child's biological mother alive?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Primary Care Giver Age <i>Select one</i>	<input type="checkbox"/> <18years <input type="checkbox"/> >=18 years <input type="checkbox"/> >50years <input type="checkbox"/> N/A (care home or unclear)			
Primary Care Giver Sex <i>Select one</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> N/A	Primary caregiver present at admission?	<input type="checkbox"/> Y <input type="checkbox"/> N	
Has the primary caregiver lived in the same household as the child for the last 2 months?			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A (care home)	
Marital status of primary caregiver <i>Select one</i>	<input type="checkbox"/> Married/monogamous <input type="checkbox"/> Married polygamous <input type="checkbox"/> Single <input type="checkbox"/> Separated / divorced <input type="checkbox"/> Widowed <input type="checkbox"/> N/A			
If not present at admission, where is the primary caregiver? <i>Select one</i>				
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A				
If the primary caregiver is present, caregiver anthropometry:				
<i>Use locally available adult scales and stadiometer, and adult MUAC tapes provided by CHAIN.</i>				
<input type="checkbox"/> Primary caregiver not present during admission, or care home				
Weight	_____ kg	MUAC	_____ cm	Height: _____ cm
Education: <i>Select highest level of education achieved</i>	<input type="checkbox"/> None <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Above secondary <input type="checkbox"/> Unknown <input type="checkbox"/> N/A care home			
Able to read?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	Is the primary caregiver primarily responsible for financial support and providing for the child?	<input type="checkbox"/> Y <input type="checkbox"/> N	
Primary caregiver HIV status in last 6 months <i>Select one</i>	<input type="checkbox"/> Tested Positive <input type="checkbox"/> Tested Negative <input type="checkbox"/> Not tested or unknown			
Have there been ANY changes to the child's social situation in the last 2 MONTHS? <i>Select any that apply,</i>				
Child moved to a different household	Y N	Relocation from rural to urban setting <i>Select 'yes' even if this is temporary</i>	Y	N
		Relocation from urban to rural setting <i>Select 'yes' even if this is temporary</i>	Y	N
		Relocation to live with different caregiver <i>Select 'yes' even if this is temporary</i>	Y	N



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Mother sick	Y	N	Mother Died	Y	N
Father sick	Y	N	Father Died	Y	N
Other primary caregiver sick	Y	N	N/A	Other primary caregiver died	Y N N/A
Primary caregiver changed	Y	N	Child went into care home	Y	N
Primary caregiver started employment / returned to school	Y	N	Person providing for the child has lost income	Y	N
Primary caregiver divorced / separated from partner	Y	N	Primary caregiver in new relationship	Y	N
Mother is pregnant	Y	N	Mother gave birth	Y	N
Other primary caregiver pregnant?	Y	N	N/A	Other primary caregiver gave birth	Y N N/A
If primary caregiver has changed in the last 2 months, who was the child's previous primary caregiver? <i>Select one</i>					
<input type="checkbox"/> Biologic Mother		<input type="checkbox"/> Biologic Father		<input type="checkbox"/> Sibling ≥18 years old	
<input type="checkbox"/> Grandparent		<input type="checkbox"/> Aunt/Uncle/Cousin		<input type="checkbox"/> Other	
				<input type="checkbox"/> Sibling <18 years old	
				<input type="checkbox"/> N/A	

12. Birth History				
Source of information	<input type="checkbox"/> Maternal/caregiver recall <input type="checkbox"/> Book/medical records			
Birth weight	____ . ____ ____ kg <input type="checkbox"/> Unknown			
Birth details <i>Select any that apply</i>	<input type="checkbox"/> Premature <input type="checkbox"/> Born small <2.5kg <input type="checkbox"/> Twin/multiple birth <input type="checkbox"/> Born at term <input type="checkbox"/> Unknown			
Delivery location <i>Select one</i>	<input type="checkbox"/> Born in hospital <input type="checkbox"/> Community facility/clinic with midwife/nurse midwife/doctor <input type="checkbox"/> Home without <input type="checkbox"/> Home with traditional <input type="checkbox"/> Home with midwife/nurse birth attendant birth attendant (untrained) <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Delivery details <i>Select all that apply</i>	<input type="checkbox"/> Normal, spontaneous vaginal <input type="checkbox"/> Assisted delivery (forceps, ventouse) <input type="checkbox"/> Caesarean section <input type="checkbox"/> Mother admitted to <input type="checkbox"/> Admitted neonatal unit <input type="checkbox"/> Unknown hospital >48h			
Mother's age at first pregnancy	____ years <input type="checkbox"/> unknown		Mother's age now	____ years <input type="checkbox"/> unknown
Participant birth order	____ of ____ total live births (e.g. if youngest of 3 children 3 of 3, if oldest of 3 children 1 of 3)			
Are the biological parents of this child consanguineous? <i>Ask if parents have relatives in common or are related.</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		



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13. Household Food Security (if child in care home include children in the care home only)		
During the past 7 DAYS has ANY member of the household missed a meal due to food shortage?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
During the past 4 WEEKS		
Did you worry that your household would not have enough food?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Were any of your household unable to eat the kinds of food preferred because of a lack of resources?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Have any of your household had to eat a limited variety of food due to lack of resources?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Have any of your household eaten some foods that you really didn't want to eat because of lack of resources?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Have any of your household eaten fewer meals in a day because there was not enough food?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Did household members go to sleep at night hungry because there was not enough food?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Did you or your household members go a whole day and night without eating anything because there was not enough food?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	

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

END



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