

CHAIN Enrolment CRF v1.63
 CHAIN Number [1][0][0][0][3][][][][]



Eligibility Checklist		
Age between 2 months and before 2 nd birthday	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

Admission to Hospital and Study Enrolment

DATE arrived at the hospital	___/___/___ <i>DD/MM/YYYY</i>	TIME arrived at the hospital	__:__:__ <i>24h Clock</i>	<input type="checkbox"/> Arrival time unknown	
DATE of enrolment <small>i.e. date consented and seen by research team</small>	___/___/___ <i>DD/MM/YYYY</i>	TIME of enrolment	__:__:__ <i>24h Clock</i>	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
DOB	___/___/___ <i>DD/MM/YYYY</i>	Is the DOB:	<input type="checkbox"/> True <input type="checkbox"/> Estimated*	Child's Initials	___
Brought into hospital by: <small>Select all that apply</small>	<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

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"/> Other (only one complaint, if not covered by above options)	

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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	_____ % Leave blank if unrecordable	<input type="checkbox"/> Measured in Oxygen	<input type="checkbox"/> Measured in Room Air <input type="checkbox"/> Unrecordable

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"/> None <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++	Initials		Measurer 1	Measurer 2
				_____	_____

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

Current Health	
Previously admitted to hospital. Include other hospitals / health centres. Select 1	<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. Select all that apply	<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? Select 1	<input type="checkbox"/> Not passing urine <input type="checkbox"/> Less than normal <input type="checkbox"/> Normal or greater <input type="checkbox"/> Unknown

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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>	
Airway <i>(select one)</i>	<input type="checkbox"/> Clear <input type="checkbox"/> Needs active support <input type="checkbox"/> Obstructed/Stridor
Breathing <i>(select all that apply)</i>	<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?	<input type="checkbox"/> Y <input type="checkbox"/> N
Skin pinch (select one)	<input type="checkbox"/> >2 seconds <input type="checkbox"/> <2 seconds <input type="checkbox"/> Immediate
Drinking/Breastfeeding <i>(Select one)</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Poorly <input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
Abdomen <i>(select any 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 abdominal mass
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
Jaundice (Select one)	<input type="checkbox"/> Not jaundiced <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++
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 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
Site of skin lesions. <i>(select any that apply)</i>	<input type="checkbox"/> Not applicable (No rash) <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs <input type="checkbox"/> Palms / soles <input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum

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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"/>
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"/>

TB Screening							
Known TB (on treatment)		Child has cough >14 days		Household contact has TB, or cough >14 days		Child has suspected extra-pulmonary TB	
Y	N	Y	N	Y	N	Y	N

Feeding						
Currently in outpatient nutrition program? <i>Select one.</i>	<input type="checkbox"/> Supplementary <i>(corn soy blend, RUSF, khichuri, halwa)</i>		<input type="checkbox"/> Therapeutic <i>(RUTF, Plumpy-nut)</i>		<input type="checkbox"/> None	
Has the child eaten these nutrition products in the last 3 days?	<input type="checkbox"/> Supplementary		<input type="checkbox"/> Therapeutic		<input type="checkbox"/> None	
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
If NO breastfeeding at all, age stopped in months? <i>(select one)</i>	<input type="checkbox"/> 0-3m	<input type="checkbox"/> 4-6m	<input type="checkbox"/> 7-12m	<input type="checkbox"/> >12m	<input type="checkbox"/> Unknown	<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"/> Formula/powder milk		<input type="checkbox"/> Animal milk	
	<input type="checkbox"/> Fruit Juice		<input type="checkbox"/> Tea		<input type="checkbox"/> Other	
	<input type="checkbox"/> Water		<input type="checkbox"/> Porridge/pulp		<input type="checkbox"/> Gutthi / gripe water	
	<input type="checkbox"/> Pure Honey		<input type="checkbox"/> Glycerine		<input type="checkbox"/> Nothing	

Vaccinations – Ask carer or check book / card if available							
BCG scar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rotavirus	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
Measles	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	Pneumococcus	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown	DTP/Penta	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	Doses received: 3 2 1 <input type="checkbox"/> Unknown
			Polio	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown

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CLINICIANS IMPRESSION OF RISK

How likely does the clinical team think this child is to die during this admission? Select one

- Almost certainly not
 Very unlikely
 Quite unlikely
 Unsure
 Quite likely
 Very likely
 Almost certainly

Immediate Clinical Investigations and HIV status

Malaria RDT circle result		Positive		Negative		Not done	
Blood glucose		_____ . ____ mmol/L		Time glucose measured		_____ : _____ 24h clock <input type="checkbox"/> Unknown	
Urine Dipstick <i>(can be done at any time during admission)</i>		Protein	Nitrites	Leucocytes	Blood	Ketones	Glucose
Urine sample stored?	Y N						
<input type="checkbox"/> Not done <input type="checkbox"/> Bag <input type="checkbox"/> Clean catch		None + ++ +++	Pos Neg	None + ++ +++	None + ++ +++	None + ++ +++	None + ++ +++
HIV status known?		<input type="checkbox"/> Yes, known PCR positive <input type="checkbox"/> Yes, antibody positive, unknown PCR status <input type="checkbox"/> Yes, known exposed, known PCR negative (children under 18m with PCR result SEEN BY RESEARCH TEAM. If 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 select one	<input type="checkbox"/> On prophylactic dose co-trimoxazole		<input type="checkbox"/> On high dose co-trimoxazole		<input type="checkbox"/> Not on co-trimoxazole <input type="checkbox"/> Caregiver unsure	
If not known positive	HIV RDT now select one	<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					
HIV test offered to caregiver?		<input type="checkbox"/> Yes, Reactive <input type="checkbox"/> Yes, Non-reactive		<input type="checkbox"/> Yes, but Declined <input type="checkbox"/> No, Caregiver is known positive		<input type="checkbox"/> Missed <input type="checkbox"/> N/A child 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			

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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
Date and time First antibiotics given	___/___/_____ <i>24h clock</i>	____:____ <input type="checkbox"/> Not given
Intravenous Antibiotics Given? <input type="checkbox"/> Not given	<input type="checkbox"/> Benzylpenicillin <input type="checkbox"/> Co-amoxiclav/ Augmentin <input type="checkbox"/> Ampicillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Ceftazidime <input type="checkbox"/> Other _____	<input type="checkbox"/> Gentamicin <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Vancomycin <input type="checkbox"/> Pivmecillinam <input type="checkbox"/> Ceftriaxone / Cefotaxime <input type="checkbox"/> Chloramphenicol <input type="checkbox"/> Meropenem / Imipenem <input type="checkbox"/> Metronidazole
Oral Antibiotics Given? <input type="checkbox"/> Not given	<input type="checkbox"/> Amoxicillin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Penicillin <input type="checkbox"/> Other _____	<input type="checkbox"/> Erythromycin <input type="checkbox"/> Metronidazole <input type="checkbox"/> Co-amoxiclav / Augmentin <input type="checkbox"/> Flucloxacillin <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Nalidixic acid <input type="checkbox"/> Levofloxacin
Initial treatment given <i>First 6 hours. Select any that apply. For IV fluid bolus, and IV fluids specify type and volume in ml, and duration</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 _____



Suspected Initial Diagnoses:

*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
<input type="checkbox"/> Pulmonary TB	<input type="checkbox"/> Extra pulmonary TB	<input type="checkbox"/> Other encephalopathy
<input type="checkbox"/> Otitis media	<input type="checkbox"/> Soft tissue infection	<input type="checkbox"/> Hydrocephalus
<input type="checkbox"/> Asthma	<input type="checkbox"/> UTI	<input type="checkbox"/> Developmental delay
General	<input type="checkbox"/> HIV related illness	<input type="checkbox"/> Cerebral palsy
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Measles	Other suspected diagnosis:
<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Varicella	<input type="checkbox"/> Other
<input type="checkbox"/> Thalassaemia	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Unknown
<input type="checkbox"/> Renal impairment	<input type="checkbox"/> Febrile illness unspecified	<input type="checkbox"/> Failed appetite test only
<input type="checkbox"/> Nephrotic syndrome	<input type="checkbox"/> Enteric fever	
<input type="checkbox"/> Nephritis		
<input type="checkbox"/> Liver dysfunction		
<input type="checkbox"/> Ileus		
<input type="checkbox"/> Congenital cardiac disease		

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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 <input type="checkbox"/> N
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 <input type="checkbox"/> N
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 Number taken <input type="checkbox"/> 1 <input type="checkbox"/> 2 Time taken ____: ____ <input type="checkbox"/> Y AFTER ABX		
Stool sample	Taken in first 24h? <input type="checkbox"/> Y <input type="checkbox"/> N Time taken ____: ____		

Chest x-ray indicated <i>(respiratory signs symptoms)</i>	<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 <i>(signs of meningitis documented)</i>	<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. <i>Do not sign if any fields are empty</i>	_____	Date ____/____/_____ <i>D D / M M / Y Y Y Y</i>	Time ____:____
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PART 2

CHAIN ADMISSION CRF: SOCIAL INFORMATION.

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
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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? *Reasons given, select one*

<input type="checkbox"/> Referred by health care worker	<input type="checkbox"/> Caregiver concern of child's condition	<input type="checkbox"/> Received money for transport to hospital (e.g. from family, neighbour, paid work)?
<input type="checkbox"/> Relative / neighbour concern of child's condition	<input type="checkbox"/> Primary caregiver returned home e.g. if working away	<input type="checkbox"/> Other

How did you travel to the hospital? *Select all that apply*

<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
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How long did it take you to travel to hospital? <1h 1- <2h 2-4h >4h > 1 day

How much did it cost the family to travel to hospital today (in local currency)? *Estimate amount. If walked or free ambulance write 0* _____

Have you sought treatment for this illness prior to coming to hospital? *Select all that apply*

<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

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? *Select one*

<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? *Select one*

<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
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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 birth attendant <input type="checkbox"/> Home with traditional birth attendant (untrained) <input type="checkbox"/> Home with midwife/nurse <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Delivery details <i>Select all that apply</i>	<input type="checkbox"/> Normal, spontaneous vaginal delivery <input type="checkbox"/> Assisted delivery (forceps, ventouse) <input type="checkbox"/> Caesarean section <input type="checkbox"/> Admitted neonatal unit <input type="checkbox"/> Mother admitted to hospital >48h <input type="checkbox"/> Unknown			
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 <i>(e.g. if youngest of 3 children 3 of 3, if oldest of 3 children 1 of 3)</i>			
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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Primary Caregiver Information			
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.			
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"/> Unknow <input type="checkbox"/> n	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
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"/> Sibling <18 years old <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle/Cousin <input type="checkbox"/> Other <input type="checkbox"/> N/A			

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Primary caregiver earns an income now? <i>Ask the person accompanying the child and select one</i>			
<input type="checkbox"/> Employed full time by someone else	<input type="checkbox"/> Employed part time by someone else		
<input type="checkbox"/> Works for self	<input type="checkbox"/> No work income		
<input type="checkbox"/> Works casually/irregularly for someone	<input type="checkbox"/> Don't know		
If works casually, Occupation:	<input type="checkbox"/> N/A care home		
How many days worked a week? <i>Select one</i>	<input type="checkbox"/> <3	<input type="checkbox"/> 3-5	<input type="checkbox"/> >5
			<input type="checkbox"/> N/A, does not work for income
If the primary caregiver earns, main source of income? <i>Select one</i>			
<input type="checkbox"/> Farmer	<input type="checkbox"/> Business/trader	<input type="checkbox"/> Labourer	<input type="checkbox"/> Domestic work
<input type="checkbox"/> Other private sector employment	<input type="checkbox"/> Public sector employment	<input type="checkbox"/> Retired with pension income	
<input type="checkbox"/> Begging	<input type="checkbox"/> Other _____	<input type="checkbox"/> N/A	
If the primary caregiver works (earning or non-earning), main place of work? <i>Select one</i>			
<input type="checkbox"/> In/around home (where child lives)	<input type="checkbox"/> Away for <4 hours per day	<input type="checkbox"/> Away >4 hours but comes home daily	
<input type="checkbox"/> Away > 8h a day but returns home daily	<input type="checkbox"/> Away >1 day, comes home weekly	<input type="checkbox"/> Away comes home, less than weekly	
<input type="checkbox"/> Primary caregiver lives and works away	<input type="checkbox"/> Don't know	<input type="checkbox"/> N/A	

The person primarily providing financial support to this child is this child's: <i>Select one</i>			
<input type="checkbox"/> Biologic Mother	<input type="checkbox"/> Biologic Father	<input type="checkbox"/> Stepfather	<input type="checkbox"/> Stepmother
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Sibling ≥18 years old	<input type="checkbox"/> Sibling <18 years old	<input type="checkbox"/> Aunt/Uncle/Cousin
<input type="checkbox"/> More than one person responsible, unclear	<input type="checkbox"/> Unsupported / care home	<input type="checkbox"/> Other -specify _____	
Person responsible for providing financial support to child, place of usual residence? <i>Select one</i>			
<input type="checkbox"/> Always sleeps at home	<input type="checkbox"/> Sleeps away but returns weekly		
<input type="checkbox"/> Sleeps away for > two months per year	<input type="checkbox"/> Works and lives abroad, contact with child once a year or less		
<input type="checkbox"/> Sleeps away but return monthly or less often	<input type="checkbox"/> Don't know		
<input type="checkbox"/> Other _____	<input type="checkbox"/> N/A (e.g. care home, unsupported)		
What is the Father or person responsible for providing financial support to child source of income? <i>Select one. If the primary carer is also the person providing financial support do not complete this section.</i>			
<input type="checkbox"/> Farmer	<input type="checkbox"/> Business/trader	<input type="checkbox"/> Labourer	<input type="checkbox"/> Domestic work
<input type="checkbox"/> Other private sector employment	<input type="checkbox"/> Public sector employment	<input type="checkbox"/> Retired with pension income	
<input type="checkbox"/> Begging	<input type="checkbox"/> None	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
			<input type="checkbox"/> N/A

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Substitute Care:					
<i>Who usually looks after child when primary caretaker is working or away? Select all that apply</i>					
<input type="checkbox"/> Not applicable, caregiver looks after child full time		<input type="checkbox"/> Not applicable, child accompanies caregiver to work			
<input type="checkbox"/> No substitute care, child left alone		<input type="checkbox"/> No substitute care / unclear		<input type="checkbox"/> Child in care home	
<input type="checkbox"/> Biological Mother	<input type="checkbox"/> Biological Father	<input type="checkbox"/> Sibling <18 years old		<input type="checkbox"/> Sibling ≥18 years old	
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle/Cousin	<input type="checkbox"/> Childcare facility outside home		<input type="checkbox"/> Childminder/ day care at home	
How many days a week is the child in day care?	<input type="checkbox"/> N/A	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> >6
How many hours per day is the child in day care?	<input type="checkbox"/> N/A	<input type="checkbox"/> 1-4h	<input type="checkbox"/> 5-8h	<input type="checkbox"/> 9-12h	<input type="checkbox"/> >12h
How many children are looked after at this day care?	<input type="checkbox"/> <3	<input type="checkbox"/> 4-6	<input type="checkbox"/> 7-10	<input type="checkbox"/> >10	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A
How many of these are under 2y?	<input type="checkbox"/> <3	<input type="checkbox"/> 4-6	<input type="checkbox"/> 7-10	<input type="checkbox"/> >10	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A
How many adults look after these children?	<input type="checkbox"/> 1	<input type="checkbox"/> 2-4	<input type="checkbox"/> 5-10	<input type="checkbox"/> >10	<input type="checkbox"/> N/A
Do you feel the day care is good?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> N/A		
Who provides food for the child at day care? Select one					
<input type="checkbox"/> Caregiver provides food for the child	<input type="checkbox"/> Day care provides food for the child	<input type="checkbox"/> Someone else provides food for the child	<input type="checkbox"/> Don't know	<input type="checkbox"/> N/A	
Is feeding supervised / assisted at day care?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A	

Household Food Security		
<i>(if child in care home include children in the care home only)</i>		
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



Child Dietary Diversity	
What does the child eat on a typical day?	
<ul style="list-style-type: none"> • Ask this as an open question and select all that the caregiver mentions. • Do not present the caregiver with this list. • You may prompt the caregiver with open questions, e.g. What does your child usually eat for breakfast 	
<input type="checkbox"/> Milk and Milk Products: Fresh/fermented milk, cheese, yogurt, or other milk products	
<input type="checkbox"/> Breast milk	
<input type="checkbox"/> Cereals and Cereal Products: Maize, rice, pasta, porridge, bread, biscuits, millet, sorghum, wheat, locally available grains	
<input type="checkbox"/> Fish and Sea Foods: fresh or dried fish or shellfish	
<input type="checkbox"/> Roots and Tubers: potatoes, sweet potatoes, yams, cassava, or foods made from roots or wild roots and tubers	
<input type="checkbox"/> Vegetables: Cabbages, carrots, spinach, and any other locally available vegetables including wild vegetables	
<input type="checkbox"/> Fruits: Oranges, bananas, mangoes, avocados, apples, grapes etc	
<input type="checkbox"/> Meats and Poultry: Camel, beef, lamb, goat, rabbit, wild game, chicken or other birds, liver, kidney, heart or other organ meats or blood-based foods	
<input type="checkbox"/> Eggs: Hen or other bird eggs	
<input type="checkbox"/> Pulses / Legumes / Nuts and Seeds: Beans, peas, lentils, nuts, seeds or foods made from these	
<input type="checkbox"/> Fats and Oils: Oil, fats, ghee, margarine or butter added to food or used for cooking	
<input type="checkbox"/> Sugars / Honey and Commercial Juices: Sugar in tea, honey, sweetened soda, juices, chocolates, sweets or candies	
<input type="checkbox"/> Miscellaneous: Spices, unsweetened beverages	
<input type="checkbox"/> UNKNOWN	

Feeding practices	
How is food USUALLY given to the child? Select one	
<input type="checkbox"/> Fed by adult	<input type="checkbox"/> Child feeds self, unsupervised
<input type="checkbox"/> Child feeds self, supervised by adult	<input type="checkbox"/> Fed from common plate or bowl
<input type="checkbox"/> Child feeds self, supervised by older children	<input type="checkbox"/> Child exclusively breastfed
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other

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Assessment of household wealth (DHS 7 questionnaire. Please answer all questions, for all participants, including children in care homes)			
What is the main source of drinking water for members of your household? Choose one			
<input type="checkbox"/> Piped water to dwelling	<input type="checkbox"/> Cart with small tank	<input type="checkbox"/> from vendor	
<input type="checkbox"/> Piped water to yard / plot	<input type="checkbox"/> Tanker truck	<input type="checkbox"/> Rainwater	
<input type="checkbox"/> Piped to neighbour	<input type="checkbox"/> Bottled water	<input type="checkbox"/> Stream/river/lake/pond/dam	
<input type="checkbox"/> Public tap/ Standpipe	<input type="checkbox"/> Protected spring	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Protected well / borehole	<input type="checkbox"/> Unprotected spring		
<input type="checkbox"/> Unprotected well	<input type="checkbox"/> Other		
What is the MAIN source of water used by your household for other purposes such as cooking and handwashing? SELECT ONE ONLY			
<input type="checkbox"/> Piped water to dwelling	<input type="checkbox"/> Cart with small tank	<input type="checkbox"/> Bought from vendor	
<input type="checkbox"/> Piped water to yard / plot	<input type="checkbox"/> Tanker truck	<input type="checkbox"/> Rainwater	
<input type="checkbox"/> Piped to neighbour	<input type="checkbox"/> Bottled water	<input type="checkbox"/> Stream/river/lake/pond/dam	
<input type="checkbox"/> Public tap/ Standpipe	<input type="checkbox"/> Protected spring	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Protected well / borehole	<input type="checkbox"/> Unprotected spring		
<input type="checkbox"/> Unprotected well	<input type="checkbox"/> Other		
How long does it take to get DRINKING water and come back? (State 0 if water supplied within home or compound)	___ ___ minutes	<input type="checkbox"/> Don't know	
In the past 2 weeks was the water from this source not available for at least one full day?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Unknown	
Do you usually do anything to the water to make it safer to drink? Select all that apply			
<input type="checkbox"/> None	<input type="checkbox"/> Bleach/ chlorine	<input type="checkbox"/> Strain through a cloth	<input type="checkbox"/> Let it stand and settle
<input type="checkbox"/> Use water filter (ceramic/sand/composite etc)	<input type="checkbox"/> Solar disinfection	<input type="checkbox"/> Boil	<input type="checkbox"/> Other

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What kind of toilet facility do members of your household usually use? <i>Select one</i>			
<input type="checkbox"/> Flush or pour flush toilet to piped sewer	<input type="checkbox"/> Flush to septic tank	<input type="checkbox"/> Ventilated improved pit latrine	
<input type="checkbox"/> Flush to pit latrine	<input type="checkbox"/> Flush to somewhere else	<input type="checkbox"/> Open pit / Pit latrine without slab	
<input type="checkbox"/> Flush don't know where	<input type="checkbox"/> Composting toilet	<input type="checkbox"/> Bucket toilet	
<input type="checkbox"/> Pit latrine with slab	<input type="checkbox"/> Hanging toilet / hanging latrine	<input type="checkbox"/> No facility / bush/ field	
<input type="checkbox"/> Unknown			
Do you share this toilet facility with other households?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
If Yes, including your own household, how many households use this toilet facility?	Number if <10__	<input type="checkbox"/> >10 households	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A
Where is this toilet facility located?	<input type="checkbox"/> In own dwelling	<input type="checkbox"/> In own yard / plot	<input type="checkbox"/> Elsewhere
How many rooms are there in the household for SLEEPING?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> >2
What is the MAIN FLOOR material of the rooms in this household? <i>Select one only</i>			
<input type="checkbox"/> Cement	<input type="checkbox"/> Earth/sand	<input type="checkbox"/> Wood	
<input type="checkbox"/> Dung	<input type="checkbox"/> Lives on boat	<input type="checkbox"/> Tiles	
<input type="checkbox"/> Carpet	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Unknown	
What is the MAIN WALL material of the rooms in this household? <i>Select one only</i>			
<input type="checkbox"/> Grass/straw/makuti	<input type="checkbox"/> Stone	<input type="checkbox"/> Wood	<input type="checkbox"/> Unknown
<input type="checkbox"/> Corrugated iron sheet/ Tin	<input type="checkbox"/> Mud/wood	<input type="checkbox"/> Brick/block	
<input type="checkbox"/> Planks/shingles	<input type="checkbox"/> No wall	<input type="checkbox"/> Other (specify) _____	
What is the MAIN ROOF material of the house in this household? <i>Select one only</i>			
<input type="checkbox"/> Grass/Thatch	<input type="checkbox"/> Tiles/Asbestos sheets	<input type="checkbox"/> Corrugated iron/ Tins	
<input type="checkbox"/> Mud	<input type="checkbox"/> Nylon papers/clothes	<input type="checkbox"/> Concrete	
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Unknown		
What is the MAIN cooking fuel used in this household? <i>Select one only</i>			
<input type="checkbox"/> Electricity	<input type="checkbox"/> LPG /Natural gas/Biogas	<input type="checkbox"/> Paraffin	
<input type="checkbox"/> Coal / Lignite	<input type="checkbox"/> Charcoal	<input type="checkbox"/> Firewood	
<input type="checkbox"/> Straw/shrubs/grass	<input type="checkbox"/> Agricultural crop	<input type="checkbox"/> Animal Dung	
<input type="checkbox"/> No food cooked in household	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Unknown	
Do you have a separate room which is used as a kitchen?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Where is this household's cooking area located?			
<input type="checkbox"/> In the house	<input type="checkbox"/> Outdoors	<input type="checkbox"/> In a separate building	<input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown

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Does this household own any livestock, herds, other farm animals or poultry	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
If yes, how many of the following animals does this household own?			
Cows/bulls__ __	Sheep__ __		
Horses/Donkeys/Mules__ __	Goats__ __		
Chickens or Ducks__ __	Other _____	number__ __	<input type="checkbox"/> N/A
Does any member of this household own land?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
If "Yes" How many acres of land does this household own?	____Acres	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
Does this household have a bank account?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household have electricity	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a radio?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a television?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a computer?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a refrigerator?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does any member of this household own:			
A watch	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A mobile phone?	<input type="checkbox"/> Y Standard phone	<input type="checkbox"/> Y smartphone	<input type="checkbox"/> N <input type="checkbox"/> Unknown
An animal-drawn cart?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A bicycle?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A motorcycle / scooter?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A car or truck?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A boat with a motor?	<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 ____/____/____ <i>D D / M M / Y Y Y Y</i>	Time ____:____
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END