SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 01:
CASE SCREENING AND ELIGIBILITY

PARTICIPANT ID | DATE OF SCREENING: DAY | MONTH | YEAR

Instructions: If at any point during the completion of this CRF, the child is determined to be not eligible, go to Q23 and answer No.

Section A: *(to be completed by a screener or a trained examiner)*

Thailand only:
Check one: ☐ 1 – Initial Screening ☐ 2 – Re-screening

If Re-screening, initial PERCH ID: ☐☐☐☐☐☐

1. Time of screening: ☐☐☐☐ *(24 hour clock)*
2. Optional local site Participant ID number(s): a. ☐☐☐☐☐☐☐☐☐
   b. ☐☐☐☐☐☐☐☐☐
   c. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
3. Sex of the child: ☐ 0 - Male ☐ 1 - Female
4. Age of the child:
   Is the child < 1 month old? ☐ 1 - YES ☐ 0 - NO
   a. If Yes: ☐☐ *days*
   b. If No: ☐☐ *months*
5. Where was the child evaluated?

☐	01 - ER
☐	02 - Main ICU
☐	03 - High care area
☐	04 - Ward
☐	05 - Outpatient department
☐	06 - Clinic *(for Dhaka and Gambia only)*
☐	99 - Other, specify: _____ *Code:* ☐☐☐

Please answer YES or NO to EVERY question.

Inclusion criteria: To be eligible for PERCH, answers to **ALL** of the following must be **Yes.**	**1 - YES**	**0 - NO**
6. Age 28 days to 59 months inclusive?	☐	☐
7. Ill with cough or difficulty breathing?	☐	☐
8. Lives in catchment area? a. If Yes, where does the child live? ☐☐☐☐☐☐ *(enter coded geographic area)* b. Was the child born in Bara? ☐1 – YES ☐0 - NO ☐ 8 - UNK	☐ **Continue if all above are checked Yes**	☐ **If any above are No, go to Q23 and tick No**

⁺=*Question does not appear in AdvantageEDC℠*

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CRF 01:
CASE SCREENING AND ELIGIBILITY

						DATE OF SCREENING:									

PARTICIPANT ID | DAY | MONTH | YEAR

(Section A: continued)

Exclusion criteria: To be eligible for PERCH, answers to **BOTH** questions 9 and 10 must be **No.**	**1 - YES**	**0 - NO**	**8 - UNK**
9. Has the child been hospitalized overnight in the past 14 days (other than hospitalization at a referring hospital for this pneumonia episode <24 hours before screening)?	☐	☐	
a. Was this child admitted overnight at a referral hospital **in the previous 24 hours** for this pneumonia episode?	☐	☐	☐
10. Has the child been discharged from the hospital in the past 30 days having been enrolled as a PERCH case?	☐ **If either Q9 or Q10 above are checked Yes, go to Q23 and tick No**	☐ **Continue if both Q9 and Q10 above are checked**	

11. Section A Comments: _____

_____

Section A completed by: _____ ***STAFF CODE***: | | | | |

⁺=*Question does not appear in AdvantageEDC℠*

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CRF 01:
CASE SCREENING AND ELIGIBILITY

PARTICIPANT ID | DATE OF SCREENING: DAY | MONTH | YEAR

Section B: Clinical Exam *(to be completed by a trained examiner only)*

12. Was a clinical exam performed on this child by a PERCH trained examiner? ☐ 1 – YES ☐ 0 - NO
    a. If No, why not? ☐ 01 - Died ☐ 02 – Refused ☐ 03 - Not referred for hospital admission
    ☐ 04 - No trained examiner
    ☐ 99 – Other, specify: _____ *Code:* ☐☐☐

13. Where was the clinical exam conducted?

☐	01 - ER	☐	04 - Ward
☐	02 - Main ICU	☐	05 – Outpatient department
☐	03 - High care area	☐	06 - Clinic *(for Dhaka and Gambia only)*
☐	Other, specify: _____ *code:* ☐☐☐		

Inclusion criteria: ***Please answer YES or NO to EVERY question.***

To be eligible for PERCH, answer to Q14h below must be **YES.**

14. Assess the following symptoms of severe and very severe pneumonia:

		1 - YES	0 - NO
a.	Lower chest wall indrawing……	☐	☐
	Very Severe:	**1 – YES**	**0 - NO**
b.	Head nodding……	☐	☐
c.	Central cyanosis……	☐	☐
d.	Unable to feed *(must be observed by examiner)*……	☐	☐
e.	Vomiting everything *(must be observed by examiner)*……	☐	☐

f. Lethargy or impaired consciousness *(assess below)*

NOTE: Wait for >30 minutes after any convulsion before carrying out assessment of consciousness.

☐	0 - A: Alert and awake
☐	1 - V: Responds to voice
☐	2 - P: Responds to pain
☐	3 - U: Unresponsive

9 – Pharmacologically sedated ☐

	1 - YES	0 - NO
+i. If 'A' or '9' is ticked above, tick 'No.' If V, P or U is ticked, tick 'Yes.'	☐	☐

g. Multiple or prolonged convulsions during this illness …*(assess below)*

Did child have convulsions? ☐ Yes ☐ No *(If no, tick 14g.ii 'No')*

i. If Yes, what kind? *(check all that apply).*

☐ **M:** multiple *(≥2 episodes)* ☐ **P**: prolonged *(≥15 min)*

☐ **S:** single brief *(<15 min)*

	1 - YES	0 - NO
+ii. *If **only** S is ticked in 14g.i above, tick 'No.' If M or P is ticked, tick 'Yes.'*	☐	☐

h. Does the child have severe or very severe pneumonia *(defined as having **ONE or MORE** items in grey outlined boxes above Q14a-g checked **YES**)?*

1 - YES	0 - NO
☐	☐
Continue	**Answer Q15-18, then skip to Q23 and tick NO**

+=*Question does not appear in AdvantageEDC℠*

CRF 01:
CASE SCREENING AND ELIGIBILITY

PARTICIPANT ID | DATE OF SCREENING: DAY | MONTH | YEAR

(Section B: continued)

15. Did a PERCH study physician verify the signs/symptoms of severe/ very severe pneumonia? **1 - YES** ☐ **0 - NO** ☐

Oxygen Saturation and Respiratory Rate

16. Is the child on O_2? *(Assess only if >30 min after seizure)* **1 - Yes** ☐ **0 - No** ☐ **8 - UNK** ☐ **9 - NR** ☐

a. If Yes, record route of administration (*check one):*

☐	1 - Nasal prongs
☐	2 - Nasal catheter
☐	3 - Mechanical ventilation
☐	4 - Face mask without reservoir
☐	5 - Non-rebreathing mask with reservoir
☐	6 - Head box
☐	8 - UNK
☐	9 - NR

b. If Yes, oxygen delivery flow rate: ☐☐.☐ *L/min* **8 - UNK** ☐ **9 - NR** ☐

17. Oxygen saturation by pulse oximetry (*on room air whenever possible*): ☐☐☐ % **8 - UNK** ☐ **9 - NR** ☐

a. Measured when child was on:

☐	1 - Oxygen
☐	2 - Room air
☐	8 - UNK
☐	9 - NR

For South Africa and Thailand only:

b. If oxygen saturation measured when child was on oxygen (Q17a='1- Oxygen'), record oxygen saturation measurement on room air *(if available from chart):* ☐☐☐ % **8 - UNK** ☐ **9 - N/A** ☐

18. Respiratory rate (# of breaths counted in 60 seconds): ☐☐☐ *per minute* **8 - UNK** ☐ **9 - NR** ☐ **7 - N/A** ☐

(only if not on assisted ventilation)

+=*Question does not appear in AdvantageEDC℠*

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➔ ***If Q14h on previous page is checked Yes, please continue. If Q14h is checked No, skip to Q23.***

19. Does this child have <u>very</u> severe pneumonia (i.e., any of Q14b-g checked YES)?

☐ 1 - YES → *Skip to Q22*

☐ 2 - NO → *Answer Q20 (i.e. child has lower chest wall indrawing but no 'very severe' signs)*

BRONCHODILATOR CHALLENGE

Inclusion criteria:

To be eligible, Q21c must be **Yes** if the child has <u>severe</u> pneumonia.

If the child has <u>very</u> severe pneumonia (i.e., any of Q14b-g is Yes), skip to Q22.

20. Does the child have lower chest wall indrawing and <u>auscultatory wheeze</u>?

☐ 1 - YES

☐ 0- NO

21. Were all required doses of bronchodilators administered before consent?

☐ 1 - YES *(complete Q21a-c below)*

☐ 8 - N/A (e.g. met quota or not during the hours of enrollment) *(skip to Q22)*

☐ 9 - NO, Pending *(complete Q21a-c when information is available)*

a. Number of bronchodilators given: ☐ *doses*

b. Does child have wheeze on auscultation after bronchodilator challenge? **1 – YES** ☐ **0 - NO** ☐

c. Is the <u>lower chest wall indrawing</u> still present after bronchodilator challenge? **1 - YES** ☐ **0 - NO** ☐

*If both Q21 and Q21c are checked No (i.e., child is ineligible), stop here and follow the **Modified Protocol**.*

Go to Q23 and tick NO

⁺=*Question does not appear in AdvantageEDC℠*

CRF 01:
CASE SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

(Section B: continued)

Admission eligibility:

To be eligible for PERCH, the answer to Q22b below must be **YES.**

22. a. What is the hospital admission status of this child? *(check one)*

☐ Admitted to study hospital → *if Yes, record the Date / Time admitted:*

DAY *MONTH* *YEAR* *(24 hour clock)*

☐ Recommended for admission to study hospital, but not admitted →

i. Will the child be available to study staff for sufficient time to complete all study procedures?

1– YES ☐ **0 - NO** ☐ *(if No, check No to Q22b below)*

ii. Specify reason not admitted:

☐ 01 - Parent refused admission
☐ 02 - Died
☐ 99 - Other, specify : _____ *Code:*

☐ Not referred for admission to study hospital → *(if checked, tick No to Q22b)*

iii. Specify reason:

☐ 01 - Physician deemed not severe enough
☐ 02 - Parent refused admission
☐ 03 - Referred to another facility
☐ 04 - Died
☐ 99 - Other, specify:_____ *Code:*

b. Does the child meet hospital admission criteria?
(Check Yes if a shaded box in Q22a or Q22ai is checked)

1 - YES ☐ **Continue**

0 - NO ☐ **Tick Q23 NO**

⁺=*Question does not appear in AdvantageEDC℠*

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CRF 01:
CASE SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

(Section B: continued)

Eligibility for PERCH	1 - YES	0 - NO
23. Is this child eligible for PERCH? Check Yes, if answers to all shaded sections of eligibility inclusion and exclusion criteria boxes are checked. i.e. If Q6-8, Q14h, Q22b, Q25 are Yes, Q21 is Yes or No, pending (as applicable), answers to Q9-10 are 'No', and Q25b is not blank, then child is eligible for PERCH.	☐ **Continue to Section C**	☐ **Stop**

24. Section B Comments: _____

_____

Clinical Exam/Eligibility Status completed by: _____

STAFF CODE

For Q23 to be Yes (child is eligible) after saving the form, ensure Section C is completed. If child is not eligible, answer N/A to Q25.

+=*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01:
CASE SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

Section C: *(to be completed by a screener or a trained examiner)*

CONSENT AND ENROLLMENT for PERCH	1 - YES	0 - NO
25. Has consent been obtained? ☐ **9- N/A (not eligible)** *Must be Yes to continue enrollment.* *If No, skip to Q25c below.*	☐ **Answer 25a and 25b**	☐ **Answer 25c**

a. If Yes, child's date of birth: *(when date of birth is uncertain, always estimate the date and check "date uncertain" box)*

DAY MONTH YEAR ☐ Date uncertain

b. If Yes, Date and time enrolled in PERCH:

DAY MONTH YEAR TIME (24 hour clock)

c. If Q25 is No, indicate reason why consent was not obtained:

☐ 01 - Refused consent
☐ 02 – Died
☐ 03 - N/A (e.g. met quota or not during the hours of enrollment)
☐ 99 - Other, specify: _____

Code:

26. Section C Comments: _____

_____

_____

Section C completed by: _____ ***STAFF CODE***:

Supervisor Signature: _____ ***STAFF CODE***:

Day ***Month*** ***Year***

⁺=*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01A:
COMMUNITY CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

Instructions: If at any point during the completion of this CRF, the child is determined to be not eligible, skip to Q13, answer NO and sign the form.

Section A: *(to be completed by a screener or a trained examiner)*

1. **TIME OF SCREENING:** ☐☐☐☐ *(24 hour clock)*

2. Optional local site Participant ID number(s): a. ☐☐☐☐☐☐☐☐☐

   b. ☐☐☐☐☐☐☐☐☐

   c. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3. Sex of the child: ☐ 0 - Male ☐ 1 - Female

4. Age of the child:

   Is the child < 1 month old? ☐ 1 – YES ☐ 0 - NO

   a. If Yes: ☐☐ *days*

   b. If No: ☐☐ *months*

5. Where was the child evaluated?

☐	01 - Home
☐	02 - Study facility
☐	03 - Health center/clinic
☐	99 - Other, specify: _____ *Code:* ☐☐☐

Continue Section A on next page…

[+] =*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01A:
COMMUNITY CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

(Section A: Continued)

Inclusion criteria: To be eligible, **BOTH** of the following must be **YES.**	**1 - YES**	**0 - NO**
6. Age 28 days to 59 months inclusive?	☐	☐
7. Lives in catchment area? a. If Yes, where does the child live? ☐☐☐☐☐☐ *(enter coded geographic area)* b. Was the child born in Bara? ☐ 1 – YES ☐ 0 - NO ☐ 8 -UNK	☐ **Continue if BOTH above are checked YES**	☐ **If either above are checked NO, go to Q13 and tick NO then stop**

Exclusion criteria: To be eligible, **ALL** of the following must be **NO**	**1 - YES**	**0 - NO**
8. Has the child been hospitalized in the past 14 days?	☐	☐
9. Has the child been discharged from the hospital in the past 30 days having been enrolled as a PERCH case?	☐ **If either above are checked YES, go to Q13 and tick NO then stop**	☐ **Continue if both above are checked NO**

Section A completed by: _____ ***STAFF CODE***: ☐☐☐☐

Continue to Section B on next page…

[+] =*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01A:
COMMUNITY CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID | DATE OF SCREENING: DAY | MONTH | YEAR

Section B: *(to be completed by a PERCH trained examiner only)*

10. Was child examined by a trained examiner for completion of this Section? ☐ 1 – YES ☐ 0 – NO

a. If No, why not? ☐ 01 – Refused ☐ 02 - No trainer examiner ☐ 03 - Unable to contact after initial screen
☐ 99 – Other, specify: _____ *Code:*

Exclusion criteria: ***Please answer YES or NO to EVERY question.*** To be eligible for PERCH, Q11 and Q12i below must be **NO.**	**1 - YES**	**0 - NO**
11. Does this child appear very sick requiring urgent medical attention? ***If Yes, child is ineligible; prompt evaluation and treatment should be sought.***	☐ **Skip to Q13 and tick NO**	☐ **Continue**
12. Assess symptoms of severe and very severe pneumonia:	**1 – YES**	**0 - NO**
a. Is child ill with cough or difficulty breathing?..... *(if No, answer all Q12b-h below, then tick No to Q12i.)*	☐	☐
	1 – YES	**0 - NO**
b. Lower chest wall indrawing.....	☐	☐
c. Head nodding.....	☐	☐
d. Central cyanosis.....	☐	☐
e. Unable to feed *(must be observed by examiner)*.....	☐	☐
f. Vomiting everything *(must be observed by examiner)*.....	☐	☐
g. Lethargy or impaired consciousness *(assess below)* *NOTE: Wait for >30 minutes after any convulsion before carrying out assessment of consciousness.* ☐ **A:** alert & awake ☐ **V:** responds to voice ☐ **P:** responds to pain ☐ **U:** unresponsive ☐ 9 - Pharmacologically sedated	**1 – YES** ☐	**0 - NO** ☐
+i. If 'A' or '9' is ticked above, tick 'No'. If V, P or U is ticked, tick 'Yes'.		
h. Multiple or prolonged convulsions during this illness …*(assess below)* Did child have convulsions? ☐ Yes ☐ No *(If no, tick Q12h.ii 'No')*		
i. If Yes, what kind? *(check all that apply):* ☐ **M:** multiple *(≥2 episodes)* ☐ **P**: prolonged *(≥15 min)* ☐ **S:** single brief *(<15 min)*	**1 – YES** ☐	**0 - NO** ☐
+ ii. *If **only** S is ticked in Q12h.i above, then tick 'No.' If M or P is ticked, then tick 'Yes.'*		
i. Does the child have severe or very severe pneumonia *(*defined as having ***cough or difficulty breathing*** *(i.e. item12a above is YES)* ***AND ONE or MORE*** *of items 12b-h above are checked YES?*	☐ **Go to Q13 and tick 'No'**	☐ **Continue**

+ =*Question does not appear in AdvantageEDC℠*

CRF 01A:
COMMUNITY CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

(Section B: continued)

Eligibility for PERCH	**1 - YES**	**0 - NO**
13. Is this child eligible for PERCH? If all shaded responses are checked, then the child is eligible for PERCH. *(i.e., answers to Q6-7 are YES, and Q8-9, Q11, and Q12i are NO, and 15b is not blank)* ***For Q13 to be Yes (child is eligible) after saving the form, ensure Section C is completed. If child is not eligible, answer N/A to Q15.***	☐ **Continue**	☐ **STOP**

14. Section B Comments:

_____

_____

Section B completed by: _____ ***STAFF CODE***:

Continue to Section C on next page…

[+] =*Question does not appear in AdvantageEDC℠*

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CRF 01A:
COMMUNITY CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

Section C: *(to be completed by a screener or trained examiner)*

CONSENT AND ENROLLMENT for PERCH	YES	NO
15. Has consent been obtained? ☐ **9- N/A (not eligible)** *Must be Yes to continue enrollment.* *If No, skip Q15a and Q15b and mark the reason why not in Q15c below.* a. If Yes, child's date of birth: *(when date of birth is uncertain, always estimate the date and check the "date uncertain" box)* DAY MONTH YEAR ☐ Date uncertain b. If Yes, Date and time enrolled in PERCH: DAY MONTH YEAR TIME (24 hour clock) c. If No, mark the reason why not: ☐ 01 - Refused consent ☐ 99 - Other, specify: _____ Code:	☐ **Answer 15a and 15b**	☐ **Answer 15c**

16. Section C Comments:

_____

_____

17. Re-enter optional local site Participant ID number:

CRF/Section C completed by: _____ ***STAFF CODE***:

Supervisor Signature: _____ ***STAFF CODE***:

Day ***Month*** ***Year***

+ =*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01B:
HIV+ CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

Instructions: If at any point during the completion of this CRF, the child is determined to be not eligible, skip to Q15, answer NO and sign the form.

Section A: to be completed by a screener or a trained examiner

1. Time of Screening: *(24 hour clock)*

2. Optional local site Participant ID number(s): a.
   b.
   c.

3. Sex of the child: ☐ 0 - Male ☐ 1 - Female

4. Age of the child:
   Is the child < 1 month old? ☐ 1 – YES ☐ 0 - NO
   a. If Yes: *days*
   b. If No: *months*

5. Where was the child recruited from? *HIV Clinic number:*

6. Where was the child evaluated?

☐	01 - Home
☐	02 - Study facility
☐	03 - Health center/clinic
☐	99 - Other, specify: _____ *Code:*

Continued on next page…

+ =*Question does not appear in AdvantageEDC℠*

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 01B:
HIV+ CONTROL SCREENING AND ELIGIBILITY

						DATE OF SCREENING:									
PARTICIPANT ID							DAY		MONTH			YEAR			

(Section A: continued)

Inclusion criteria: ***Please answer YES or NO to EVERY question.*** To be eligible for PERCH, **ALL** of the following must be **YES**	**1 - YES**	**0 - NO**
7. Age 28 days to 59 months inclusive?	☐	☐
8. Lives in catchment area? a. If Yes, where does the child live? ☐☐☐☐☐☐ *(enter coded geographic area)* b. Was the child born in Bara? ☐ 1 – YES ☐ 0 - NO ☐ 8 - UNK	☐	☐
9. Is the child confirmed as HIV positive? *If Yes,* a. Source of confirmation of HIV status: ☐ 01 - Hospital outpatient folder ☐ 02 - HIV Clinic folder ☐ 03 - Laboratory database ☐ 99 - Other _____ *Code:* ☐☐ b. If Yes, has the child had <3 months of ART treatment? ☐ 1 – YES ☐ 0 – NO ☐ 8 - UNK	☐ **Continue if <u>all</u> above are ticked**	☐ **If <u>any</u> above are ticked, go to Q17 and tick NO**

If ALL shaded boxes in Q7-9 are checked YES and Q9b is checked either YES or NO, continue to next page. If any of Q7-9 is checked NO or Q9b is checked UNK, sign Section A then check Q17 NO and stop.

[+] *=Question does not appear in AdvantageEDC℠*

CRF 01B:
HIV+ CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID | DATE OF SCREENING: DAY | MONTH | YEAR

(Section A: continued)

Exclusion criteria: To be eligible for PERCH, answers to **ALL** of the following must be **NO**.	**1 - YES**	**0 - NO**
10. Has the child been hospitalized in the past 14 days?	☐	☐
11. Has the child been discharged from the hospital in the past 30 days having been enrolled as a PERCH case?	☐	☐
12. Has the child been admitted to the hospital in the past 30 days for an acute illness?	☐ **If <u>any</u> above are ticked, go to Q17 and tick NO**	☐ **Continue if <u>all</u> above are ticked**

13. Section A Comments: _____

_____

Section A completed by: _____ ***STAFF CODE***:

Continue to Section B on next page if responses to Q8-10 above are all NO…

[+] =*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01B:
HIV+ CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID | DATE OF SCREENING: DAY | MONTH | YEAR

Section B: to be completed by a trained examiner

14. Was child examined by a trained examiner for the completion of this Section? ☐ 1 – YES ☐ 0 - NO

a. If No, why not? ☐ 01 – Refused ☐ 02 - Admin error
☐ 99 - Other, specify: _____ *Code:* ☐☐☐

Exclusion criteria: ***Please answer YES or NO to EVERY question.*** To be eligible for PERCH, Q15 and Q16i below must be **NO.**	**1 - YES**	**0 - NO**
15. Does this child appear very sick requiring urgent medical attention? ***If Yes, child is ineligible; prompt evaluation and treatment should be sought.***	☐ **Skip to Q17 and tick NO**	☐ **Continue**
16. Assess the following symptoms of severe and very severe pneumonia:		
a. Is child ill with cough or difficulty breathing?..... *(if No, answer all Q16b-h below, then tick No to Q16i.)*	☐	☐
b. Lower chest wall indrawing.....	☐	☐
c. Head nodding…….....	☐	☐
d. Central cyanosis.....	☐	☐
e. Unable to feed *(must be observed by examiner)*.....	☐	☐
f. Vomiting everything *(must be observed by examiner)*.....	☐	☐
g. Lethargy or impaired consciousness … *(assess below)*..... *NOTE: Wait for >30 minutes after any convulsion before carrying out assessment of consciousness.* ☐ **A:** alert & awake ☐ **V:** responds to voice ☐ **P:** responds to pain ☐ **U:** unresponsive ☐ 9 - Pharmacologically sedated	**1 – YES** ☐	**0 - NO** ☐
+i. If 'A' or '9' is ticked above, tick 'No'. If V, P or U is ticked, tick 'Yes'		
h. Multiple or prolonged convulsions during this illness …*(assess below)* Did child have convulsions? ☐ Yes ☐ No *(If no, tick Q16h.ii 'No')*		
i. If Yes, what kind? *(check all that apply):* ☐ **M:** multiple *(≥2 episodes)* ☐ **P**: prolonged *(≥15 min)* ☐ **S:** single brief *(<15 min)*	**1 – YES** ☐	**0 - NO** ☐
+ii. *If **only** S is ticked in Q16h.i above, then tick 'No.' If M or P is ticked, then tick 'Yes.'*		
i. Does the child have severe or very severe pneumonia *(*defined as having ***cough or difficulty breathing*** *(i.e. item16a above is YES)* ***AND ONE or MORE*** *of items 16b-h above are checked YES)?*	☐ **Go to Q17 and tick 'No'**	☐ **Continue**

+ =*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01B:
HIV+ CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID | DATE OF SCREENING: DAY | MONTH | YEAR

(Section B: continued)

Eligibility for PERCH	1 - YES	0 - NO
17. Is this child eligible for PERCH? If all shaded responses are checked, then the child is eligible for PERCH. *(i.e., answers to Q7-9 and Q19 are YES, and Q10-12, Q15 and Q16i are NO, and Q9b is not UNK, and Q19b is not blank)*	☐ **Continue**	☐ **Stop**

18. Section B Comments: _____

_____

Section B completed by: _____ ***STAFF CODE***:

For Q17 to be Yes (child is eligible) after saving the form, ensure Section C is completed. If child is not eligible, answer N/A to Q19.

[+] =*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 01B:
HIV+ CONTROL SCREENING AND ELIGIBILITY

PARTICIPANT ID

DATE OF SCREENING: DAY MONTH YEAR

Section C: *(to be completed by a screener or a trained examiner)*

CONSENT AND ENROLLMENT for PERCH	1 - YES	0 - NO
19. Has consent been obtained? ☐ **9- N/A (not eligible)** *Must be Yes to continue enrollment.* *If No, skip Q19a and Q19b and mark the reason why not in Q19c below.* a. If Yes, child's date of birth: *(when date of birth is uncertain, always estimate the date and check the date uncertain box)* DAY MONTH YEAR ☐ Date uncertain b. If Yes, Date and time enrolled in PERCH: DAY MONTH YEAR TIME (24 hour clock) c. If No, reason why not: ☐ 01 - Refused consent ☐ 99 - Other, specify: _____ Code:	☐ **Answer 19a and 19b**	☐ **Answer 19c**

20. Section C Comments: _____

_____

Section C completed by: _____ ***STAFF CODE***

Supervisor Signature: _____ ***STAFF CODE***

Day ***Month*** ***Year***

+ =*Question does not appear in AdvantageEDC℠*

SITE LOGO

CRF 03:
CLINICAL HISTORY

PARTICIPANT ID

DATE OF CLINICAL HISTORY: DAY MONTH YEAR

CURRENT HEALTH STATUS

1. Has the child had any of the following symptoms *(by parent/caregiver report or observed by physician)*?

Symptom	Symptom present? 1 - YES 0 - NO 9 - NR	If YES, duration *in days (xx)* *(1=today)*
a. Fever:	☐ ☐ ☐	☐☐
b. Cough:	☐ ☐ ☐	☐☐
c. Difficulty breathing:	☐ ☐ ☐	☐☐
d. Wheeze:	☐ ☐ ☐	☐☐
e. Unable to feed:	☐ ☐ ☐	☐☐
f. Runny nose:	☐ ☐ ☐	☐☐
g. Ear discharge:	☐ ☐ ☐	☐☐
h. Vomiting:	☐ ☐ ☐	☐☐
i. Diarrhea (≥3 abnormally loose or watery stools per day)	☐ ☐ ☐	☐☐
i) If Yes, was there blood in the stool?	☐ ☐ ☐	
j. Has the child had abnormal sleepiness or been difficult to wake?	☐ ☐ ☐	☐☐
k. Other:_____ *Code:* ☐☐☐	☐ ☐ ☐	☐☐
l. Other:_____ *Code:* ☐☐☐	☐ ☐ ☐	☐☐

NOTE: If a <u>control</u> develops difficulty breathing, is unable to drink/breastfeed, or becomes very lethargic, child should be taken to hospital/clinic to be seen.

SITE LOGO

CRF 03: CLINICAL HISTORY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID | DATE OF CLINICAL HISTORY: DAY | MONTH | YEAR

MEDICATIONS (*prior to hospital presentation)*

2. Was the child given any medication for this illness in the past 48 hours? ***(If No or UNK, go to Q3.)*** **1-YES 0-NO 8-UNK 9-N/A** (N/A for non-ill controls)

Medication	Given?
a. Anti-malarials?	1-YES 0-NO 8-UNK 9-NR
b. Antibiotics?	1-YES 0-NO 8-UNK 9-NR
c. Fever medication / Analgesics / Antipyretics?	1-YES 0-NO 8-UNK 9-NR
d. Bronchodilators	1-YES 0-NO 8-UNK 9-NR
e. Traditional medicine?	1-YES 0-NO 8-UNK 9-NR

3. Did the child get antibiotics at the referral hospital before being sent to study hospital? **1-YES 0- NO 8-UNK 9-N/A**

   a. If Yes, route of administration:

☐	01 - IV
☐	02 - IM
☐	03 - PO
☐	08 - UNK
☐	09 - NR
☐	99 – Other
	Other, specify:_____ *Code:* ☐☐☐

   b. Did the child get steroids at the referral hospital before being sent to the study hospital? **1-YES 0- NO 8-UNK 9-N/A**

PAST MEDICAL HISTORY

4. Has the child been admitted to a hospital since birth? ***(If No or UNK, go to Q5.)*** **1 - YES 0 - NO 8 - UNK** **# of admissions** If YES, ☐☐

   a. If Yes, was the child ever admitted for Pneumonia? **1 - YES 0 - NO 8 - UNK** **# of admissions** If YES, ☐☐

5. Has the child ever been diagnosed with wheezing or asthma? **1 - YES 0 - NO 8 - UNK**

   a. If Yes, are wheezing medications regularly taken at home?

6. Has child had measles in the past month? **1 - YES 0 - NO 8 - UNK**

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CRF 03: CLINICAL HISTORY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE OF CLINICAL HISTORY: DAY MONTH YEAR

HIV Exposure

Maternal HIV – History

During Pregnancy

7a. Was the mother known to be HIV positive *during* pregnancy with this child? 1-YES 0-NO 8-UNK

7ai. Source of HIV status during pregnancy *(check all that apply)*:

☐ Self-report ☐ Documented test results

7aii. If HIV positive, does the mother receive HAART? 1-YES 0-NO 8-UNK

If Yes, for how long?: ☐ ☐ ☐ ☐☐ 8-UNK ☐

Days Months Years

7aiii. Does the child receive prophylactic nevirapine (NVP)? 1-YES 0-NO 8-UNK

If Yes, indicate duration: ☐ ☐ ☐☐ *(xx)* 8-UNK ☐

Weeks Months

7aiv. Does the child receive prophylactic Cotrimoxazole (Bactrim, Septrim)? 1-YES 0-NO 8-UNK

If Yes, indicate duration: ☐ ☐ ☐☐ *(xx)* 8-UNK ☐

Weeks Months

After Pregnancy

Only required if 7a is No or UNK

7b. Has the mother received a positive HIV result since the birth of this child? 1-YES 0-NO 8-UNK

7bi. Source of post-partum HIV status *(check all that apply)*:

☐ Self-report ☐ Documented test results within the last 6 months

7bii. If HIV positive, does the mother receive ART? 1-YES 0-NO 8-UNK

If yes, for how long?: ☐ ☐ ☐ ☐☐ *(xx)* 8-UNK ☐

Days Months Years

Maternal HIV – Test Results

Only required if 7a and 7b are No or UNK

7c. Was the mother tested for HIV at the PERCH Clinic? 1- YES 0-NO 2-REFUSED 9-N/A

7ci. If yes, Maternal RVD test results: 1- POS 2 - NEG 3 - IND

SITE LOGO

CRF 03: CLINICAL HISTORY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE OF CLINICAL HISTORY: DAY MONTH YEAR

Child HIV

8. Is the child known to be HIV positive? 1-YES 0-NO 8-UNK

(If No or UNK, go to Q9)

If Yes, child is HIV positive, answer the following questions:

a. Does the child receive HAART? 1-YES 0-NO 8-UNK

i. If Yes, date HAART initiated: *Day* *Month* *Year* 8-UNK

b. Has the child attended a HAART clinic in the past 3 months? 1-YES 0-NO 8-UNK

c. Has the child had CD4 cell counts measured in the past 3 months?

<u>If Yes, record the most recent CD4 results:</u>

i. Date of CD4 test: *Day* *Month* *Year* 8-UNK

ii. CD4 number: / mm^3 8-UNK

iii. CD4 percent: . % 8-UNK

SITE LOGO

CRF 03: CLINICAL HISTORY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID | DATE OF CLINICAL HISTORY: DAY | MONTH | YEAR

TUBERCULOSIS

9. Is the child living in the same household with someone on TB treatment? 1 - YES 0 – NO 8 - UNK
(If NO or UNK, go to Q10)

   a. If Yes, how long has the TB contact been on treatment? ____ *months* 8 - UNK

   b. If Yes, how was the TB diagnosed?

☐	01 - CXR
☐	02 – AFB positive sputum
☐	03 - Clinical
☐	04 – TB skin test *(if close contact is another child)*
☐	08 - UNK
☐	99 – Other
	Other, specify:_____ *Code:* ____

   c. If Yes, what regimen is the contact being treated with?

☐	1 – Oral medication
☐	2 – Oral and injectables
☐	03 - UNK

10. Has this child ever been diagnosed with TB? 1 - YES 0 – NO 8 - UNK

   a. If Yes, has this child ever received TB treatment?
(If No or UNK, go to Q11.)

      i. If YES, current TB treatment status:

☐	1 – On treatment
☐	2 – Completed treatment
☐	3 - Defaulted
☐	8 - UNK

11. Has the child had noticeable weight loss or failed to gain weight? 1 - YES 0 – NO 8 - UNK

OTHER UNDERLYING CONDITIONS

12. Did your child drink paraffin in the past 48 hours? 1 - YES 0 – NO 8 - UNK

   a. If Yes, how many days ago? *(1=today)* ____ *days* 8 - UNK

   b. If Yes, did someone see the child drink the paraffin?..... 1 - YES 0 – NO 8 - UNK

13. Thalassemia?..... 1 - YES 0 – NO 8 - UNK

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PERCH
Pneumonia Etiology Research for Child Health

CRF 03:
CLINICAL HISTORY

PARTICIPANT ID

DATE OF CLINICAL HISTORY: DAY MONTH YEAR

IMMUNIZATION HISTORY

14. Does the child have their immunization records with them? 1 - YES 0 – NO 8 - UNK

15. Has the child had Vitamin A supplements in the last 6 months?

16. Has the child had any of the following vaccinations? 8 - UNK (for all vaccinations)
(If Yes, list the date of each dose.)

	Dose	1-YES	0-NO	8-UNK	If Yes, Date Received DAY	MONTH	YEAR	Date Estimated
a. BCG	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
b. DTP-HiB (Combact-HiB)	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	4.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
c. DTP only	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	4.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
d. DTaP only	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	4.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	5.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
e. DTP-HepB	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
f. **DTP-HiB-HepB (Penta)**	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐

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CRF 03:
CLINICAL HISTORY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE OF CLINICAL HISTORY: DAY MONTH YEAR

	Dose	1-YES	0-NO	8-UNK	If Yes, Date Received DAY	MONTH	YEAR	Date Estimated
g. **DTaP-HiB-IPV (Pentaxim)**	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	4.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
h. HepB	1.	☐	☐	☐				☐
	2.	☐	☐	☐				☐
	3.	☐	☐	☐				☐
i. HIB	1.	☐	☐	☐				☐
	2.	☐	☐	☐				☐
	3.	☐	☐	☐				☐
	4.	☐	☐	☐				☐
j. OPV ***(Date received field available for 01KEN site only)***	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	4.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	5.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
k. PCV	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	4.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
l. Rotavirus	1.	☐	☐	☐				☐
	2.	☐	☐	☐				☐
	3.	☐	☐	☐				☐

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PERCH
Pneumonia Etiology Research for Child Health

CRF 03:
CLINICAL HISTORY

PARTICIPANT ID

DATE OF CLINICAL HISTORY: DAY MONTH YEAR

	Dose	1-YES	0-NO	8-UNK	If Yes, Date Received DAY	MONTH	YEAR	Date Estimated
m. Japanese Encephalitis	1.	☐	☐	☐				☐
	2.	☐	☐	☐				☐
	3.	☐	☐	☐				☐
n. Measles	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	3.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
o. MMR	1.	☐	☐	☐				☐
p. Influenza (for the current season)	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
	2.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
q. MR	1.	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐

17. If child is <9 months of age, has the <u>mother</u> had any of the following vaccinations during her pregnancy with this child?

(If Yes, list the date of the last dose if more than one.)

☐ 8 - UNK (for all vaccinations)

☐ *9* - N/A (i.e., child > 9 months)

	1-YES	0-NO	8-UNK	If Yes, Date of Last Dose DAY	MONTH	YEAR	Date Estimated
a. Influenza (for the current season)	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
b. DTaP	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
c. PCV	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐
d. PPS-23	☐	☐	☐	☐☐	☐☐☐	☐☐☐☐	☐

Comments: _____

_____

Interviewer's Name: _____ ☐☐☐☐ *STAFF CODE*

Supervisor Signature: _____ ☐☐☐☐ *STAFF CODE*

Supervisor Verification Date: ☐☐ ☐☐☐ ☐☐☐☐

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PERCH
Pneumonia Etiology Research for Child Health

CRF 04:
CASE CLINICAL ASSESSMENT

PARTICIPANT ID

Date of assessment: DAY MONTH YEAR

1. Time of assessment: _____ *(24 hour clock)*

2. Where is child being assessed?

☐	01 - Hospital
☐	02 - Clinic
☐	99 - Other, specify: _____ Code: _____

3. Was child referred from another health clinic/hospital?

☐	1 - Yes →	a. Clinic/hospital name: _____ Code: _____
☐	0 - No	
☐	8 - UNK	

NUTRITION / HYDRATION STATUS / VITAL SIGNS

4. Temperature (axillary): _____ . _____ °C — 8 - UNK ☐

5. Height/length: _____ . _____ *cm* — 8 - UNK ☐

6. Was the child weighed alone? 1 - Yes ☐ 0 - No ☐

If No, child's weight will be calculated in AdvantageEDC℠.

6a. Weight of child: _____ . _____ *kg* — 8 - UNK ☐

7. Weight of mother and child: _____ . _____ *kg* — 8 - UNK ☐

8. Weight of mother: _____ . _____ *kg* — 8 - UNK ☐

9. Mid-Upper Arm Circumference (MUAC) *(N/A for children <3 months old)*: _____ *mm* — 8 - UNK ☐ 9 – N/A ☐

10. Heart rate: _____ *beats per minute* — 8 - UNK ☐

14. Pedal edema:

☐	1 – Yes
☐	2 - No
☐	8 - UNK
☐	9 - NR

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PERCH Pneumonia Etiology Research for Child Health

CRF 04:
CASE CLINICAL ASSESSMENT

PARTICIPANT ID | Date of assessment: DAY MONTH YEAR

15. Skin turgor:

☐	1 - Normal
☐	2 - Reduced
☐	8 - UNK
☐	9 - NR

16. Capillary refill time: ☐ *seconds* 8 - UNK ☐ 9 - NR ☐

	1 - Yes	0 - No	8 - UNK	9 - NR
17. Cool peripheries (cool hands and feet):……	☐	☐	☐	☐
18. Weak peripheral pulses (Radial/Dorsalis pedis pulse):……	☐	☐	☐	☐
19. Gallop rhythm:……	☐	☐	☐	☐
20. Tender liver mass (With/without hepatomegaly):……	☐	☐	☐	☐

RESPIRATORY SIGNS (in addition to those recorded on CRF 01)

	1 - Yes	0 - No	8 - UNK	9 - NR
21. Observed cough:……				
a. If Yes, is it a barking cough?.....	☐	☐	☐	☐
22. Stridor:……	☐	☐	☐	☐
a. If Yes, is the stridor still present when the child is quiet (not crying?)	☐	☐	☐	☐
23. Grunting:……	☐	☐	☐	☐
24. Nasal flaring:……	☐	☐	☐	☐
25. Deep breathing:……	☐	☐	☐	☐
26. Is there an audible wheeze?.....	☐	☐	☐	☐

27. Does the child have any of the following findings on chest auscultation?

Findings:	Left side				Right side			
	1 - Yes	0 - No	8 - UNK	9 - NR	1 - Yes	0 - No	8 - UNK	9 - NR
a. Wheeze:	☐	☐	☐	☐	☐	☐	☐	☐
b. Crackles/Crepitations:	☐	☐	☐	☐	☐	☐	☐	☐
c. Decreased breath sounds:	☐	☐	☐	☐	☐	☐	☐	☐
d. Bronchial breath sounds:	☐	☐	☐	☐	☐	☐	☐	☐

e. Auscultation findings were done by: 8 – UNK ☐ 9 - NR ☐

☐	01 - Hospital staff
☐	02 - PERCH staff
☐	99 - Other, specify:_____ Code: ☐☐☐

28. Clubbing:…… 1 - Yes ☐ 0 - No ☐ 8 - UNK ☐ 9 - NR ☐

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 04:
CASE CLINICAL ASSESSMENT

PARTICIPANT ID

Date of assessment: DAY MONTH YEAR

29. Was a digital stethoscope recording taken?..... 1 - Yes 0 - No 8 - UNK 9 - NR

a. If Yes, enter the sound file record number: (D D M M Y Y - x x x x x)

b. Time of recording: *(24 hour clock)*

c. Digital auscultation comments: _____

_____

_____

MISCELLANEOUS SIGNS

30. Jaundice:..... 1 - Yes 0 - No 8 - UNK 9 - NR

31. Bulging fontanelle (if < 18 months): ..... 10 - N/A

32. Rash:.....

a. If Yes, type of rash? *(check one)* 8 – UNK 9 - NR

☐	01 - Petechial (size of individual lesions < 3 mm)
☐	02 - Purpural (size of individual lesions ≥ 3 mm)
☐	03 - Measles
☐	04 - Chicken pox
☐	99 - Other, specify:_____ *Code:*

33a. Clinical *pneumonia* diagnosis made by hospital staff on admission *(check one):*

☐ 1 – Non-severe pneumonia/ Pneumonia not otherwise specified
☐ 2 – Severe pneumonia
☐ 3 – Very severe pneumonia
☐ 4 – No pneumonia diagnosis
☐ 9 – Not available/ Not done by hospital

33b. Other clinical diagnosis made by hospital staff on admission *(check all that apply):*

☐ Pulmonary TB
☐ Extrapulmonary TB
☐ Bronchiolitis/RSV
☐ Asthma / Reactive Airway Disease (RAD)
☐ Measles
☐ Malaria
☐ Meningitis
☐ Gastroenteritis
☐ HIV
☐ Presumptive septicaemia
☐ Paraffin ingestion
☐ Severe anaemia
☐ Sickle cell disease
☐ Severe malnutrition
☐ Bronchitis
☐ Developmental delay/Cerebral palsy
☐ Other:_____ *Code:*
☐ Other:_____ *Code:*
☐ Other:_____ *Code:*
☐ Not available/Not done by hospital
☐ Pneumonia diagnosis only

SITE LOGO

CRF 04:
CASE CLINICAL ASSESSMENT

PARTICIPANT ID

Date of assessment: DAY MONTH YEAR

Comments:_____

_____

Form completed by: _____ ***Staff Code***:

Supervisor signature: _____ ***Staff Code***:

Day ***Month*** ***Year***

SITE LOGO

CRF 04A:
CONTROL CLINICAL ASSESSMENT

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date of assessment: DAY MONTH YEAR

NUTRITION / HYDRATION STATUS / VITAL SIGNS

1. Were any signs or symptoms of illness in the last 48 hours reported? (1 - Yes 0 - No 8 - UNK)
   (Question 1 on CRF03)
   a. If Yes, temperature: ___.___ °C SOURCE: 1-Auxillary 2-Rectal 8 - UNK
2. Height/length: ___.___ cm 8 - UNK
3. Was the child weighed alone? 1 - Yes 0 - No
   If No, child's weight will be calculated in AdvantageEDC[SM].
3a. Weight of child: ___.___ kg 8 - UNK
4. Weight of mother and child: ___.___ kg 8 - UNK
5. Weight of mother: ___.___ kg 8 - UNK
6. Mid-upper arm circumference (MUAC)
   (N/A for children <3 months old): ___ mm 8 - UNK 9 – N/A
7. Respiratory rate *(# of breaths counted in 60 seconds)*: ___ *per min* 8 - UNK

RESPIRATORY SIGNS

8. Observed cough? …… 1 - Yes 0 - No 8 - UNK
9. Was a digital stethoscope recording taken? 1 - Yes 0 – No 8-UNK 9 - NR
   a. If Yes, enter the sound file record number: D D M M Y Y - x x x x x
   b. Time of recording: ____ *(24 hour clock)*
   c. Digital auscultation comments:

_____

_____

_____

10. Clubbing: …… 1 - Yes 0 – No 8 - UNK 9 - NR

MISCELLANEOUS SIGNS

11. Rash: …… 1 - Yes 0 – No 8 - UNK 9 - NR
    a. If Yes, type of rash? *(check one)*

☐	01 - Petechial (size of individual lesions < 3 mm)
☐	02 - Purpural (size of individual lesions ≥ 3 mm)
☐	03 - Measles
☐	04 - Chicken pox
☐	08 - UNK
☐	09 - NR
☐	99 - Other, specify:_____ *Code:* ___

SITE LOGO

CRF 04A:
CONTROL CLINICAL ASSESSMENT

PERCH
Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date of assessment: DAY | MONTH | YEAR

Comments:_____

_____

_____

Form completed by: _____ ***Staff Code***:

Supervisor Signature: _____ ***Staff Code***:

Day ***Month*** ***Year***

SITE LOGO

CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID | DAY | MONTH | YEAR

1. Are you a primary caregiver for this child? …… 1-YES ☐ 0- NO ☐ 8-UNK ☐

2. What is your relationship to him or her *(choose one)?* 08 - UNK ☐

☐ 01 - Mother ☐ 02 - Father ☐ 03 - Grandmother ☐ 04 - Grandfather
☐ 05 - Brother ☐ 06 - Sister ☐ 07 - Aunt ☐ 09 - Uncle
☐ 10 - Other relative ☐ 11 - Maid / Baby sitter
☐ 99 – Other, specify: _____ *Code:* ☐☐☐

DEMOGRAPHICS

3. Mother's ethnic group *(choose one):* 98 - UNK ☐

☐	14 - Asian	☐	71 - Vietnamese
☐	51 - Xhosa	☐	72 - Bambara
☐	52 - Zulu	☐	73 - Malinké
☐	53 - Coloured	☐	74 - Sarakolé
☐	54 - Sotho	☐	75 - Peuhl
☐	55 - Bemba	☐	76 - Bobo
☐	56 - Lozi	☐	77 - Sénoufo
☐	57 - Chewa	☐	78 - Minianka
☐	58 - Tonga	☐	79 - Bozo
☐	59- Lunda	☐	80 - Somono
☐	60 - Luvale	☐	81 - Dogon
☐	61 - Kaonde	☐	82 - Sonrhái
☐	62 - Mandinka	☐	83 - Maure
☐	63 - Wollof	☐	84 - Tamachek
☐	64 - Fula	☐	85 - Samoko
☐	65 - Serahule	☐	86 - Dafing
☐	66 - Jola	☐	87 - Thai
☐	67 - Aku	☐	88 - Lao
☐	68 - Manjago	☐	89 - Cambodian
☐	69 - Serere	☐	90 -Bangladeshi
☐	70 - Ndebele	☐	91 - Soli
☐	99 - Other, specify: _____ *Code:* ☐☐☐		

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

4. Father's ethnic group *(mark only one):*

98 - UNK ☐

☐	14 - Asian	☐	71 - Vietnamese
☐	51 - Xhosa	☐	72 - Bambara
☐	52 - Zulu	☐	73 - Malinké
☐	53 - Coloured	☐	74 - Sarakolé
☐	54 - Sotho	☐	75 - Peuhl
☐	55 - Bemba	☐	76 - Bobo
☐	56 - Lozi	☐	77 - Sénoufo
☐	57 - Chewa	☐	78 - Minianka
☐	58 - Tonga	☐	79 - Bozo
☐	59- Lunda	☐	80 - Somono
☐	60 - Luvale	☐	81 - Dogon
☐	61 - Kaonde	☐	82 - Sonrhái
☐	62 - Mandinka	☐	83 - Maure
☐	63 - Wollof	☐	84 - Tamachek
☐	64 - Fula	☐	85 - Samoko
☐	65 - Serahule	☐	86 - Dafing
☐	66 - Jola	☐	87 - Thai
☐	67 - Aku	☐	88 - Lao
☐	68 - Manjago	☐	89 - Cambodian
☐	69 - Serere	☐	90 -Bangladeshi
☐	70 - Ndebele	☐	91 - Soli
☐	99 - Other, specify: _____ *Code:* ☐☐☐		

5. Has the child been previously enrolled as a PERCH case or control?

(check all that apply) ☐ 0 - No ☐ 8 – UNK ☐ Case ☐ Control

(If No or UNK, skip to Q6)

If previously enrolled:

a. 1st previous PERCH participant ID #: ☐☐☐☐☐☐

b. 2nd previous PERCH participant ID #: ☐☐☐☐☐☐

c. 3rd previous PERCH participant ID #: ☐☐☐☐☐☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

6. Was the child enrolled in any intervention studies in the past year? 1-YES 0-NO 8-UNK
(i.e. has the child received medicines, vaccines, vitamins, etc. as part of a study?)
(If no or unknown, skip to Q7)

If Yes, please provide the name of the other studies and the associated ID numbers:

Study name: *(or description of intervention if name UNK)*	8 - UNK	ID number in the other study:	8 - UNK
a1. _____	b1.		
a2. _____	b2.		
a3. _____	b3.		
a4. _____	b4.		

HOUSEHOLD INFORMATION

7. Is the biological mother of child still alive? 1- Yes 0- No 8-UNK

If Yes, record the mother's age ____ *years* 8-UNK

If No, estimate the mother's age at the time of the child's birth ____ *years* 8-UNK
(Estimate using major events if needed.)

8. How many years of formal education has the mother / primary caregiver completed? ____ *years* 8-UNK

9. What type of school did the mother / primary caregiver attend? *(check all that apply)*

☐	Unknown
☐	No formal education
☐	Formal education
☐	Religious education
☐	College (and beyond)

10. Does the mother / primary caregiver belong to any social group?

11. Is the father of child still alive? *(if no, skip to Q15)* 1-YES 0-NO 8-UNK

12. How many years of formal education has the father completed? ____ *Years* 8-UNK

13. What type of school did the father attend? *(check all that apply)*

☐	Unknown
☐	No formal education
☐	Formal education
☐	Religious education
☐	College (and beyond)

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DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID | DAY | MONTH | YEAR

14. How many current wives does the father have?..... 8-UNK

    a. If more than one wife, what is the order number of the child's mother? (1=first wife, 2=second wife, etc.) 8-UNK

For Qs 15-17, respond for the most common living situations of the child during the past 12 months.

15. How many (total) people usually live in the same household as this child? *(Defined as sharing a cooking pot/area.)* 8-UNK

16. How many children aged 0-10 years (including study child) live in the same household?

17. How many people usually slept in the same room as this child in the last month (including the study child)? 8-UNK

18. For people usually sleeping in the same room as this child, record the following details:

Person #	a. **Relationship to child:** *(1-Mother, 2-Father, 3-Sibling, 4-Other child, 5-Other adult)*	b. **Age** *(nearest year)* *(If UNK, request a missing value in EDC)*	c. **Sleep in same bed?** 1-Yes	0- No	8-UNK	d. **Had a cough in the last month?** 1-Yes	0-No	8- UNK
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

19. How many live deliveries has mother had? *(including the study child; twins counts as one.)* 8-UNK
    (If 1 or more, answer Q19a; otherwise skip to Q20)

    a. Of the live deliveries reported in Q19, how many of her children have died? 8-UNK

20. Does this child attend out of home care (nursery/preschool/family care/crèche)? 1-YES 0-NO 8-UNK
    (Must include at least 2 other children for at least 4 hours per day, 3 days a week)

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID | DAY | MONTH | YEAR

ENVIRONMENT & SANITATION

21. What is the **main** source of drinking water for child's household? *(check only one response)*

08-UNK ☐

- ☐ 01-Piped into house (indoor tap water)
- ☐ 02-Piped into yard/compound/property
- ☐ 03-Bought (tank, bottles, etc)
- ☐ 04-Outdoor / Public tap
- ☐ 05- Borehole
- ☐ 06-Open well in house or yard
- ☐ 07-Covered well in house or yard
- ☐ 09-Open public well
- ☐ 10-Covered public well
- ☐ 11-Deep tube well
- ☐ 12-Shallow tube well
- ☐ 13-Protected spring
- ☐ 14-Unprotected spring
- ☐ 15-Dam or earth pan
- ☐ 16-Rainwater
- ☐ 17-River, stream, pond or lake water
- ☐ 99-Other, specify:_____

Code: ☐☐☐

22. Where is the nearest drinking water source? *(check one)*

08-UNK ☐

☐	01-Inside house
☐	02-Inside compound ≤5m of house
☐	03-Inside compound >5m of house
☐	04-Outside compound → *if checked*, record time to reach in minutes: ☐☐☐ 8- UNK ☐
☐	99-Other, specify: _____ *Code:* ☐☐☐

23. What is the main source of water for washing hands in your household? *(check one)*

08-UNK ☐

☐	01-Piped into house (indoor tap water) *(If checked, skip Q24 and go to Q25)* a. If piped into house, how many working taps/sinks with running water are located inside your house? ☐ 8-UNK ☐
☐	02-Piped into yard / property
☐	03-Outdoor / public tap
☐	04-Public well
☐	05-Rainwater
☐	06-River, stream, pond, or lake water
☐	07-Pumped from ground through bore hole
☐	09-Protected spring
☐	10-Unprotected spring
☐	11-Tube well
☐	12-Covered well in house or yard
☐	99-Other, specify: _____ *Code:* ☐☐☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

24. How long does it take to reach the water source used for washing hands? ☐☐☐ *Mins* 8-UNK ☐

25. In the last 24 hours, have you used soap and water to wash your hands? 1-YES ☐ 0-NO ☐ 8- UNK ☐

26. Does your household have a shared basin with standing water for washing hands? 1-YES ☐ 0-NO ☐ 8-UNK ☐

a. If yes, how many times per day is the water changed? *(if <1 time per day, put 0)* ☐☐ 8-UNK ☐

27. How often does your household run out of water for washing hands? *(check one)* 8-UNK ☐

☐	1- More than 10 days every month
☐	2- 5-10 days every month
☐	3- 1-4 days per month
☐	4- Occasionally but not every month
☐	5- Never

28. How concerned are you about the cost of water used for washing hands? *(check one)* 8-UNK ☐

☐	1-Not at all concerned
☐	2-Somewhat concerned
☐	3-Very concerned

29. What are the <u>floors</u> in the child's house primarily made of? (check one) 08-UNK ☐

☐	01 - Natural floor (sand/earth/dung)
☐	02 - Rudimentary floor (wood/palm/bamboo)
☐	03 - Finished floor (wood/tiles/cement/carpet)
☐	99 - Other, specify: _____ *Code:* ☐☐☐

30. What are the <u>walls</u> in the child's house primarily made of? *(check one)* 08-UNK ☐

☐	01 - Bricks
☐	02 - Tin / iron sheeting
☐	03 - Mud / mud stick / bamboo / traditional
☐	04 - Cement / concrete / coral
☐	05 - Wood
☐	06 - Plaster
☐	07 - Stone
☐	99-Other, specify: _____ *Code:* ☐☐☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

31. What is the roof in the child's house primarily made of? *(check one)*

08-UNK ☐

☐	01 - Thatch
☐	02 - Tin / iron sheeting / metal / corrugated
☐	03 - Cement / concrete
☐	04 - Wood
☐	05 - Tiled
☐	06 - Asbestos
☐	99 - Other, specify: _____ *Code:* ☐☐☐

32. What type of toilet does child's house have? *(check one)*

08-UNK ☐

☐	01 - Flush toilet
☐	02 - Modern toilet without flush
☐	03 - Ventilated, well-kept pit latrine
☐	04 - Open pit latrine
☐	05 - Bucket system
☐	06 - None / outdoors
☐	99 - Other, specify: _____ *Code:* ☐☐☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID | DAY | MONTH | YEAR

*For Q33-39, respond for the most common situation for the child. For controls, ask about **during the past month.** For cases, ask about the month **before** the child became ill with pneumonia symptoms since the period when they were ill might have been atypical for the family.*

33. Describe the type of cooking fuel you used *in the past month*:

08- UNK ☐ 9 - N/A ☐

Fuel type	a. What was the main cooking fuel? *(check one)*	b. What other fuel types did you use? *(check all that apply)*
01-Animal dung	☐	☐
02 - Crop wastes	☐	☐
03 - Wood	☐	☐
04 - Straw/shrubs/grass	☐	☐
05 - Charcoal	☐	☐
06 - Coal / ignite	☐	☐
07 - Kerosene/Paraffin	☐	☐
09- Gas	☐	☐
10 - Electricity	☐	☐
99 - Other (specify)	☐ _____ *Code:* ☐☐☐	☐ _____ *Code:* ☐☐☐

If animal dung, crop wastes, wood, straw/shrubs/grass, charcoal, coal/ignite, kerosene/paraffin was checked as the main fuel source in Q33 above, please answer Q34. Otherwise, skip to Q38.

34. What was the main stove type that you used for cooking? *(check one)*

8-UNK ☐

☐	01 - Stove: Traditional open
☐	02 - Stove: Enclosed
☐	03 - Stove: Advanced type (modern design, may have a fan to improve combustion)
☐	04 - 3-stone fire *(if checked, skip to Q35)*
☐	05 - Kerosene wick *(if checked, skip to Q35)*
☐	06 - Pressurized kerosene *(if checked, skip to Q35)*
☐	99 - Other, specify: _____ *Code:* ☐☐☐

a. If you used a stove or open fire, does it have a functioning chimney or hood?

1-YES ☐ 0-NO ☐ 8-UNK ☐ 9 - N/A ☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

35. Where did you usually cook with fuel *in the past month*? *(check one)* 8-UNK ☐

☐	1 - In the house, but in a room separate from living/sleeping area
☐	2 - In the house, part of the living / sleeping area
☐	3 - Outside the house or in a separate building

36. How many open windows does the room have where the cooking is done? ☐ 8-UNK ☐ 9-N/A ☐

37. Typically, where was the study child when the mother / caretaker was cooking with fuel *in the past month (before the child became ill)? (check one)* 8-UNK ☐

☐	1 - On her back
☐	2 - In the cooking area, but not on her back
☐	3 - Not in the cooking area (e.g. outside, in another room, etc)

38. What was the main method used to light your home when it was dark *in the past month*? *(check one)* 8-UNK ☐

☐	01 - None (did not light home)
☐	02 - Used light from cooking stove
☐	03 - Candles
☐	04 - Kerosene (paraffin) wick lamp
☐	05 - Kerosene (paraffin) pressure lamp
☐	06 - Gas
☐	07 - Electricity
☐	09 - Battery powered lamp
☐	10 - Solar
☐	99 - Other, specify: _____ *Code:* ☐☐☐

39. Did you use a fire to heat your home *in the past month*?

a. If Yes, how often? 8-UNK ☐

☐	1 - Everyday
☐	2 - Most days (16-29 days)
☐	3 - Many days (5-15 days)
☐	4 - Few days (<5 days)

40. Does anyone who lives in the same household as the child smoke cigarettes? 1-YES ☐ 0-NO ☐ 8-UNK ☐

41. Does your household have any mosquito nets that can be used while sleeping? 1-YES ☐ 0-NO ☐ 8-UNK ☐
If Yes, answer Q41a-b. If No or UNK, skip to Q42.

a. Did this child sleep under the mosquito net last night? 1-YES ☐ 0-NO ☐ 8-UNK ☐

b. Does this child usually sleep under a mosquito net? 1-YES ☐ 0-NO ☐ 8-UNK ☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

HEALTHCARE UTILIZATION

Minute guidelines:
1 hour = 60 minutes
2 hours = 120 minutes
3 hours = 180 minutes

42. Record the *usual* travel time to the following locations by the *usual* mode of transport and the *usual* costs associated with this travel.

Location:	i. How long does it usually take *(minutes)*?	ii. How much does transportation usually cost? *(in local currency, one way)*
a. Nearest health post / clinic	8-UNK	8- UNK 9-N/A
b. Study hospital	8-UNK	8- UNK 9-N/A
c. Is the study hospital the nearest hospital?	1-YES 0-NO 8-UNK	
d. Nearest hospital (*If nearest hospital is the study hospital, answer N/A.)*	8- UNK 9-N/A	8- UNK 9-N/A

*For **Cases** only, ask Q43-44. For **Controls**, skip to Q45.*

43. How long did it take to get to the study hospital for this admission *(minutes)*? 8-UNK

44. How much was the cost of transportation for this hospital admission *(one way)*? 8- UNK 9-N/A

HOUSEHOLD INCOME & ASSETS

For Q45-47, reference site-specific codelist.

45. What is the occupation of the head of household? Site-specific code:

If Other, specify: _____ Other code:

46. Father's occupation *(if not head of household):* Site-specific code:

If Other, specify:_____ Other code:

47. Mother's/primary care giver's occupation: Site-specific code:

If Other, specify: _____ Other code:

08- UNK

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DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID | DAY | MONTH | YEAR

48. What was the weekly/monthly cash income of the household last month?

☐	01 - 0 – 500 Rand	☐	07 - 0-1,000 baht
☐	02 - 501 – 1,000 Rand	☐	09 - 1,001-2000 baht
☐	03 - 1,001 – 3,000 Rand	☐	10 - 2,001-4,000 baht
☐	04 - 3,001 – 5,000 Rand	☐	11 - 4,001-7,000 baht
☐	05 - 5,001 – 15,000 Rand	☐	12 - >7,000 baht
☐	06 - >15,000 Rand		

49. Ask mother / primary caregiver: Do you regularly earn any income yourself? 1-YES ☐ 0-NO ☐ 8-UNK ☐

50. Is the child receiving a “child grant”? 1 -YES ☐ 0-NO ☐ 8-UNK ☐

51. Does your household have any of the following which are in working order? 8-UNK ☐

(*check all that apply)*

☐ Electricity	☐ Television	☐ Bicycle / rickshaw
☐ Generator	☐ Satellite TV/DS TV	☐ Boat with a motor
☐ Air conditioner	☐ Radio	☐ Canoe
☐ Electric Fan	☐ Mobile phone	☐ Sewing machine
☐ Computer	☐ Electric Iron	☐ Water heater
☐ Refrigerator	☐ Watch	☐ Washing machine
☐ Animal-drawn cart	☐ Camera	☐ None of these
☐ Clock	☐ Car / truck	
☐ DVD/Video Player	☐ Motorcycle / scooter	

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DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

52. Does anyone in the household own any of the following livestock? *(For all that apply, check and enter how many are owned. Confirm by observation where possible and appropriate.)*

Livestock	Check all that apply	i. If checked, how many owned?	8 - UNK
a. Cattle	☐	☐☐☐☐	☐
b. Sheep	☐	☐☐☐☐	☐
c. Goats	☐	☐☐☐☐	☐
d. Horses	☐	☐☐☐☐	☐
e. Donkeys	☐	☐☐☐☐	☐
f. Pigs	☐	☐☐☐☐	☐
g. Chickens	☐	☐☐☐☐	☐
h. None of these	☐		

53. Does your household own at least five items of furniture? 1 -YES ☐ 0-NO ☐ 8-UNK ☐

Furniture	Check all that apply
a. Table	☐
b. Chair	☐
c. Sofa	☐
d. Bed	☐
e. Armoire	☐
f. Cabinet	☐

54. Does any member of this household own agricultural land? 1 -YES ☐ 0-NO ☐ 8-UNK ☐

a. If yes, specify how many acres? ☐☐☐☐ 8-UNK ☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

BIRTH AND DELIVERY MILESTONES

55. Place of birth: 08- UNK ☐

☐	01 - Hospital
☐	02 - Clinic
☐	03 - Home
☐	99 - Other, specify: _____ *Code:* ☐☐☐

56. Mode of delivery: 8-UNK ☐

☐	1 - Vaginal
☐	2 - C-section

57. Gestational age…… ☐☐ *weeks* 8-UNK ☐

58. Was this child premature (<37 weeks recorded) at birth? 1-YES ☐ 0-NO ☐ 8-UNK ☐

59. How much did the child weigh at birth? ☐.☐☐ *kg* 8-UNK ☐

a. If exact weight is unknown, what was the child's size at birth? 8-UNK ☐

☐	1 – Small
☐	2 – Medium
☐	3 – Large

60. How was this child fed since s/he was born?

	Given at any stage?	i. If Yes, age first started *(Enter "00" if from birth)*	ii. If stopped, age stopped *(check N/A if still continuing)*
	1-Yes 0-No 8-UNK	Age (months)	Age (months)
a. Breast feeding	☐ ☐ ☐	☐☐ 8-UNK ☐	☐☐ 8-UNK ☐ 9-N/A ☐
b. Infant formula	☐ ☐ ☐	☐☐ 8-UNK ☐	☐☐ 8-UNK ☐ 9-N/A ☐
c. Any liquids other than breast milk (e.g. water, tea) or semi-solid food (e.g. pap)	☐ ☐ ☐	☐☐ 8-UNK ☐	☐☐ 8-UNK ☐ 9-N/A ☐
d. Solid food	☐ ☐ ☐	☐☐ 8-UNK ☐	☐☐ 8-UNK ☐ 9- N/A ☐

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CRF 05:
DEMOGRAPHICS & ENVIRONMENTAL RISK FACTORS

PARTICIPANT ID | DAY | MONTH | YEAR

61. Was the child breastfed? ..... 1-YES ☐ 0-NO ☐ 8-UNK ☐

a. For how many months was the child exclusively breastfed? ☐☐ 8-UNK ☐

b. For how many months was the child breastfed? ☐☐ 8-UNK ☐

c. Was the child breastfed in the week before illness (or the week before enrollment for controls)? 8-UNK ☐

☐	1 - Exclusive
☐	2 - Mixed
☐	3 - None

Comments: _____

_____

_____

_____

_____

_____

Form Completed by: _____ ***Staff Code:*** ☐☐☐☐

Supervisor Signature: _____ ***Staff Code:*** ☐☐☐☐

☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

CRF 06:
CASE SPECIMEN COLLECTION: BLOOD, NP/OP, URINE

PARTICIPANT ID

1. Child's weight category *(check one):* ☐ 1: ≤ 1 kg ☐ 2: > 1 kg to < 3 kg ☐ 3: ≥ 3 kg

Child's Weight	**Total Volume**	Blood Culture Bottle Volume	EDTA Tube #1 (CBC) Volume	EDTA Tube #2 (PCR) Volume	Plain/Red Top Tube Volume
≤ 1 kg	**3 mL**	1 mL	0.5 mL	1 mL	0.5 mL
> 1 kg to < 3 kg	**4.5 mL**	2 mL	0.5 mL	1 mL	1 mL
≥ 3 kg	**5 mL**	2 mL	0.5 mL	1.5 mL	1 mL

In instances of limited blood volume, the following guidance applies in decreasing order of priority:

1) Blood cultures
   CBC
   malaria slides (for endemic sites)
   HIV serology (for high prevalence sites)
2) Purple top tube for PCR, etc., (up to 1 mL max.)
3) If there is sufficient volume, any remaining blood should be placed in the red top tube

*Volume may vary based on local requirements for CBC and risk factor tests.

When < *3mL of blood* is collected from a patient, the following guidelines may be used:

Total Volume Available	Blood Culture Bottle Volume	EDTA Tube #1 (CBC*) Volume	EDTA Tube #2 (PCR) Volume	Plain/ Red Top Tube Volume
< 1 mL	all	0 mL	0 mL	0 mL
1 to < 2 mL	1 mL	0.5* mL	0 - 0.5 mL	0 mL
2 to < 3 mL	1 mL	0.5* mL	0.5 – 1 mL	Any remaining volume

2. Enrollment category (check one):

☐	Child had wheeze at admission AND the case defining signs of severe pneumonia resolved after 1 dose of bronchodilator treatment (< 2 yrs old) or after 1 - 3 doses (≥ 2 to < 5 yrs old).	→	**Modified protocol: Collect blood and swabs only. Do not collect other specimens.**
☐	Either (a) child did not have wheeze, (b) child had very severe pneumonia, or (c) signs of severe pneumonia persisted after complete course of bronchodilator therapy.	→	**Proceed with standard protocol.**

SITE LOGO

CRF 06:
CASE SPECIMEN COLLECTION: BLOOD, NP/OP, URINE

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

3. Were the following samples collected?		Reason, if not collected*	Date (ddMMMyyyy& Time (24hr clock)	Collected by	Specimen ID/Barcode
a. Blood culture	☐ Yes, at study facility ☐ Yes, at referring facility ☐ Not collected	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	DAY: ☐☐ MONTH: ☐☐☐ 8 - UNK ☐ YEAR: ☐☐☐☐ TIME: ☐☐☐☐ 8 -UNK ☐	Initials: _____ Staff code: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
b. EDTA tube #1 (CBC)	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	DAY: ☐☐ MONTH: ☐☐☐ 8 -UNK ☐ YEAR: ☐☐☐☐ TIME: ☐☐☐☐ 8 -UNK ☐	Initials: _____ Staff code: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
c. EDTA tube #2 (PCR)	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	DAY: ☐☐ MONTH: ☐☐☐ 8 - UNK ☐ YEAR: ☐☐☐☐ TIME: ☐☐☐☐ 8 - UNK ☐	Initials: _____ Staff code: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
d. Plain/ red top tube	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	DAY: ☐☐ MONTH: ☐☐☐ 8 - UNK ☐ YEAR: ☐☐☐☐ TIME: ☐☐☐☐ 8 - UNK ☐	Initials: _____ Staff code: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

*Reason Codes: 01 = Parent/Guardian refused; 02 = Child died prior to specimen collection; 03 = Insufficient blood volume; 04 = All EDTA being collected in one tube; 05=Child discharged; 07 = Child could not produce specimen; 08 = Unknown; 09 = Not applicable; 99 = Other (give reason and enter other specify code)

SITE LOGO

CRF 06:
CASE SPECIMEN COLLECTION: BLOOD, NP/OP, URINE

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

4. Were the following samples collected?		Reason, if not collected*	Date (ddMMMyyyy) & Time (24hr clock)	Collected by	Specimen ID/Barcode
a. NPS-VTM	☐ YES ☐ NO	Reason code: Other: _____ Other specify code:	DAY: MONTH: YEAR: TIME: 8 - UNK	Initials: _____ Staff code: 8 - UNK	**Flocked NP swab and OP swab should be put together in one VTM vial (one barcode label only).** Scan or affix barcode label:
b. OPS	☐ YES ☐ NO	Reason code: Other: _____ Other specify code:	DAY: MONTH: YEAR: TIME: 8 - UNK UNK	Initials: _____ Staff code: 8 - UNK	
c. NPS-STGG	☐ YES ☐ NO	Reason code: Other: _____ Other specify code:	DAY: MONTH: YEAR: TIME: 8 - UNK	Initials: _____ Staff code: 8 - UNK	**Rayon NP swab should be put in STGG vial.** Scan or affix barcode label:

*Reason Codes: 01 = Parent/Guardian refused; 02 = Child died prior to specimen collection; 03 = Insufficient blood volume; 04 = All EDTA being collected in one tube; 05=Child discharged; 07 = Child could not produce specimen; 08 = Unknown; 09 = Not applicable; 99 = Other (give reason and enter other specify code)

SITE LOGO

CRF 06:
CASE SPECIMEN COLLECTION: BLOOD, NP/OP, URINE

PERCH
Pneumonia Etiology Research for Child Health

PARTICIPANT ID

5. Was the following sample collected?		Reason, if not collected*	Date (ddMMMyyyy) & Time (24hr clock)	Collected by	Specimen ID/Barcode
a. Urine	☐ Yes, sterile cup ☐ Yes, urine bag or catheter ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	DAY: ☐☐ MONTH: ☐☐☐ 8 -UNK ☐ YEAR: ☐☐☐☐ TIME: ☐☐☐☐ 8 -UNK ☐	Initials: _____ Staff code: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

*Reason Codes: 01 = Parent/Guardian refused; 02 = Child died prior to specimen collection; 03 = Insufficient blood volume; 04 = All EDTA being collected in one tube; 05=Child discharged; 07 = Child could not produce specimen; 08 = Unknown; 09 = Not applicable; 99 = Other (give reason and enter other specify code)

Comments:

_____

_____

_____

Supervisor Signature: _____ *Staff code:* ☐☐☐☐

Supervisor Verification Date: ☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

CRF 06A:
CONTROL SPECIMEN COLLECTION: BLOOD, NP/OP, URINE

PERCH
Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date specimens collected: DAY MONTH YEAR

Volume of Blood Collection Guidelines:

EDTA Volume	Plain/Red Top Volume	Total Volume
2 mL	2 mL	4 mL

In instances where less than the minimum volume is obtained, at least 1mL should be collected in the EDTA tube.

1. Specimens collected by: _____ Staff code:

2. Were the following samples collected?		Reason, if not collected*	Time of specimen collection (24hr clock)	Specimen ID (barcode label)
a. EDTA tube	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	TIME: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
b. Plain/ red top tube	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	TIME: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
c. Dried blood spot ***Collect only for HIV PCR testing***	☐ YES ☐ NO ☐ N/A	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	TIME: ☐☐☐☐ 8 - UNK ☐	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

* Reason codes: 01 = Parent/Guardian refused; 02 = Phlebotomist unable to collect blood; 05 = Child discharged; 07 = Child could not produce specimen; 08 = Unknown; 99 = Other (give other reason or enter the other specify code if available)

SITE LOGO

CRF 06A:
CONTROL SPECIMEN COLLECTION: BLOOD, NP/OP, URINE

PERCH
Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date specimens collected: DAY MONTH YEAR

3. Were the following samples collected?		Reason, if not collected*	Time of specimen collection (24hr clock)	Specimen ID (barcode label)
a. NPS-VTM	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	TIME: ☐☐☐☐ 8 - UNK ☐	**Flocked NP swab and OP swab should be put together in one VTM vial (one barcode label only).** Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
b. OPS	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	TIME: ☐☐☐☐ 8 - UNK ☐	
c. NPS-STGG	☐ YES ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	TIME: ☐☐☐☐ 8 - UNK ☐	**Rayon NP swab should be put in STGG vial.** Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
d.Urine	☐ YES, sterile cup ☐ YES, urine bag ☐ NO	Reason code: ☐ Other: _____ Other specify code: ☐☐☐	TIME: ☐☐☐☐ 8 - UNK ☐ Date of urine collection if different from date above: ☐☐ ☐☐☐ ☐☐☐☐ *Day Month Year*	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

Comments: _____

_____

_____

Supervisor Signature: _____ *Staff code:* ☐☐☐☐

Supervisor Verification Date: ☐☐ ☐☐☐ ☐☐☐☐
Day Month Year

* Reason codes: 01 = Parent/Guardian refused; 02 = Phlebotomist unable to collect blood; 05 = Child discharged; 07 = Child could not produce specimen; 08 = Unknown; 99 = Other (give other reason or enter the other specify code if available)

SITE LOGO

CRF 07:
CASE SPECIMEN COLLECTION: INDUCED SPUTUM

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

Do not complete this form if case is in the "modified protocol" category.

- *Induced sputum should be collected within 24 hours of admission whenever possible.*
- *If induced sputum is not collected within 24 hours, a gastric aspirate specimen should be obtained. Attempts should still be made to obtain induced sputum after 24 hours post-admission.*

SECTION A – FIRST INDUCED SPUTUM (IS)

1. Was an endotracheal tube (ETT) aspirate collected from an intubated patient? (1 - Yes / 0 - No)

   [Note: If an endotracheal tube (ETT) aspirate was collected from an intubated patient, skip to question 3]

2. At the initial assessment, does the child have any of the following contraindications to IS collection: (9 - N/A)

   (N/A should only be selected if the subject died before contraindications could be assessed for specimen collection)

	1 - Yes	0 - No
a. Oxygen saturation < 92% on supplemental oxygen: ……		
b. Inability to protect airways: ……		
c. Severe bronchospasm: ……		
d. Seizure within the past 24 hours: ……		
e. Deemed inappropriate by the clinician for another reason: ……		

If the answer to any of the above is Yes, do not collect induced sputum at this time. Wait and evaluate the child again at a later point.

	1 - Yes	0 - No	If No, reason not collected *(check all that apply):*
3. Was IS or ETT aspirate collected within 24 hrs of admission? *(If Yes, skip to Q5)*	☐	☐	☐ Child met one or more clinical contraindications ☐ Parent/guardian refused ☐ Child died prior to collection of specimen ☐ Other, specify: _____ ☐ Unknown *Code:* ☐☐☐
4. Was IS or ETT aspirate collected more than 24 hrs after admission?	☐	☐	☐ Child met one or more clinical contraindications ☐ Parent/guardian refused ☐ Child died prior to collection of specimen ☐ Other, specify: _____ ☐ Unknown *Code:* ☐☐☐

SITE LOGO

CRF 07:
CASE SPECIMEN COLLECTION: INDUCED SPUTUM

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

	1 - Yes	0 - No	If No, reason not collected *(check all that apply):*
5. Was a gastric aspirate specimen collected?	☐	☐	☐ Not applicable induced sputum was collected before gastric aspirate was considered *(If Not applicable is selected, skip remainder of reasons)* ☐ Child met one or more clinical contraindications ☐ Parent/guardian refused ☐ Child died prior to collection of specimen ☐ Other, specify: _____ ☐ Unknown *Code:*

If no specimen was collected (Q3-5 are 'NO'), this form is complete. Sign and date at end.
- If an ETT aspirate was collected (Q1='Yes'), complete CRF 07ETT.
- If an IS was collected, continue with completion of this form.
- If a Gastric Aspirate was collected (Q5='Yes'), complete CRF 07GA.

6. Was an IS sample collected? ☐ 1 – Yes ☐ 0 - No

First IS collection:

a. Date/time of first IS collection: *Day* *Month* *Year* *(24 hr clock)*

b. IS collection performed by: _____ **Staff Code:**

c. Enter IS specimen ID (barcode label): Scan or affix barcode label here: —

SAFETY MONITORING

7. List any clinical findings that are relevant to this procedure:

_____

_____

_____

_____

8. Was the induced sputum procedure stopped because oxygen saturation levels dropped below 88%?

☐ 1 – Yes ☐ 0 – No ☐ 8 – UNK

SITE LOGO

CRF 07:
CASE SPECIMEN COLLECTION: INDUCED SPUTUM

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

9. Record the following clinical measures:

Time point	i. Oxygen requirement *(XX.X, L/min)* *(N/A if not on O_2)*	ii. Oxygen saturation *(%)*	iii. Respiratory Rate *(per minute)*	iv. Conscious Level* *(check one)* A=Alert and awake V= Responds to voice P=Responds to pain U= Unresponsive PS= Pharmacologically sedated
A. Immediately prior to IS procedure	. 8 – UNK 9 – N/A	8 – UNK 9 – NR	8 – UNK 9 - N/A	0 – A 1 – V 2 – P 3 – U 8 – UNK 9 - PS
B. Immediately following IS procedure	. 8 - UNK 9 – N/A	8 - UNK 9 – NR	8 - UNK 9 - N/A	0 – A 1 – V 2 – P 3 – U 8 – UNK 9 - PS
C. 30 minutes after IS procedure	. 8 - UNK 9 – N/A	8 - UNK 9 – NR	8 - UNK 9 - N/A	0 – A 1 – V 2 – P 3 – U 8 – UNK 9 - PS
D. 2 hours after IS procedure	. 8 - UNK 9 – N/A	8 - UNK 9 – NR	8 - UNK 9 - N/A	0 – A 1 – V 2 – P 3 – U 8 – UNK 9 - PS
E. 4 hours after IS procedure	. 8 - UNK 9 – N/A	8 - UNK 9 – NR	8 - UNK 9 - N/A	0 – A 1 – V 2 – P 3 – U 8 – UNK 9 - PS

*A: Alert & awake V: Responds to voice P: Responds to pain
U: Unresponsive PS: Pharmacologically sedated

SITE LOGO

CRF 07:
CASE SPECIMEN COLLECTION: INDUCED SPUTUM

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

10. Were any of the following observed <u>within four hours</u> following the induced sputum procedure?	1 - Yes	0 - No	8 - UNK
a. Drop in oxygen saturation below 92%, resulting in increased supply of supplemental oxygen for 10 minutes or more	☐	☐	☐
b. New onset of unconsciousness or prostration	☐	☐	☐
c. New requirement for bronchodilator or increased frequency of bronchodilator treatment	☐	☐	☐
d. Death	☐	☐	☐

If any response above is marked Yes, notify the local safety monitor and complete CRF 16 (Case SAE).

SITE LOGO

CRF 07:
CASE SPECIMEN COLLECTION: INDUCED SPUTUM

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

SECTION B – ADDITIONAL INDUCED SPUTUM

11. Was an additional induced sputum specimen collected during hospitalization? **1- Yes** ☐ **0 -No** ☐

(If No, sign and end form.)

a. If Yes, specify reason *(check all that apply):*

☐ Suspected TB ☐ Treatment failure ☐ Routine

b. Date/time of additional IS collection:

Day *Month* *Year* *(24 hr clock)*

c. IS collection performed by: _____ **Staff Code:**

d. Enter IS specimen ID (barcode label):

Scan or affix barcode label: ____ ____ ____ ____ ____ ____ — ____ ____

SAFETY MONITORING

12. List any clinical findings that are relevant to this procedure:

_____

_____

_____

13. Was the induced sputum procedure stopped because oxygen saturation levels dropped below 88%?

☐ 1 – Yes ☐ 0 – No ☐ 8 - UNK

14. Record the following clinical measures:

Time point	i. Oxygen requirement *(XX.X, L/min)* *(N/A if not on O_2)*	ii. Oxygen saturation *(%)*	iii. Respiratory Rate *(per minute)*	iv. Conscious Level* *(check one)*
A. Immediately prior to IS procedure	____ . ____ 8 – UNK ☐ 9 – N/A ☐	____ 8 – UNK ☐ 9 – NR ☐	____ 8 – UNK ☐ 9 - N/A ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐

SITE LOGO

CRF 07:
CASE SPECIMEN COLLECTION: INDUCED SPUTUM

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

Time point	i. Oxygen requirement *(XX.X, L/min)* *(N/A if not on O_2)*	ii. Oxygen saturation *(%)*	iii. Respiratory Rate *(per minute)*	iv. Conscious Level* *(check one)*
B. Immediately following IS procedure	☐☐.☐ 8 – UNK ☐ 9 – N/A ☐	☐☐☐ 8 – UNK ☐ 9 – NR ☐	☐☐☐ 8 – UNK ☐ 9 - N/A ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐
C. 30 minutes after IS procedure	☐☐.☐ 8 – UNK ☐ 9 – N/A ☐	☐☐☐ 8 – UNK ☐ 9 – NR ☐	☐☐☐ 8 – UNK ☐ 9 - N/A ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐
D. 2 hours after IS procedure	☐☐.☐ 8 – UNK ☐ 9 – N/A ☐	☐☐☐ 8 – UNK ☐ 9 – NR ☐	☐☐☐ 8 – UNK ☐ 9 - N/A ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐
E. 4 hours after IS procedure	☐☐.☐ 8 - UNK ☐ 9 – N/A ☐	☐☐☐ 8 - UNK ☐ 9 – NR ☐	☐☐☐ 8 - UNK ☐ 9 - N/A ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐

*A: Alert & awake V: Responds to voice P: Responds to pain
U: Unresponsive PS: Pharmacologically sedated

SITE LOGO

CRF 07:
CASE SPECIMEN COLLECTION: INDUCED SPUTUM

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

15. Were any of the following observed <u>within four hours</u> following the second induced sputum procedure?	1 - Yes	0 - No	8 - UNK
a. Drop in oxygen saturation to below 92%, resulting in increased supply of supplemental oxygen for 10 minutes or more	☐	☐	☐
b. New onset of unconsciousness or prostration	☐	☐	☐
c. New requirement for bronchodilator or increased frequency of bronchodilator treatment	☐	☐	☐
d. Death	☐	☐	☐

If any response above is marked Yes, notify the local safety monitor and complete CRF 16 (Case SAE).

Comments:

_____

_____

_____

SECTION A:
Form Completed by: _____ ***Staff Code:***

Supervisor Signature: _____ ***Staff Code:***

Supervisor Verification Date: DAY MONTH YEAR

SECTION B:
Supervisor Signature: _____ ***Staff Code:***

Supervisor Verification Date: DAY MONTH YEAR

SITE LOGO

CRF 07ETT:
CASE SPECIMEN COLLECTION: Endotracheal (ETT) Aspirate

PARTICIPANT ID

Specimen number: ☐☐

Date specimen collected: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

1. Time of ETT aspirate collection: ☐☐☐☐ *TIME (24 hour clock)* **8 - UNK** ☐

2. Specimen collected by Staff Code:: ☐☐☐☐

3. ETT aspirate specimen ID (barcode label): Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

Comments: _____

_____

_____

Supervisor Signature: _____ ***STAFF CODE***: ☐☐☐☐

☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

CRF 07GA:
CASE SPECIMEN COLLECTION: GASTRIC ASPIRATE

PARTICIPANT ID

DATE SPECIMEN COLLECTED: DAY MONTH YEAR

1. Time of gastric aspirate collection: ☐☐☐☐ 8 - UNK ☐
   TIME (24 hour clock)

2. Specimen collected by Staff Code: ☐☐☐☐

3. Gastric aspirate specimen ID (barcode label): Scan or affix barcode label ☐☐☐☐☐☐ – ☐☐

Comments: _____

_____

_____

Supervisor Signature: _____ ***STAFF CODE***: ☐☐☐☐

Day ☐☐ ***Month*** ☐☐☐ ***Year*** ☐☐☐☐

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 08:
CASE CXR

PARTICIPANT ID

Date of CXR: DAY MONTH YEAR

1. Time of CXR: ☐☐☐☐ *(24 hour clock)* ☐ 9 - N/A ***(if no CXR taken, skip all questions and sign form at end)***

2. Is this the initial or a follow-up CXR? ☐ 1 – Initial ☐ 2 - Follow-up

3. Was an antero-posterior or postero-anterior view image taken? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK
(If NO or UNK, go to Q4)

If Yes, insert specimen ID (barcode label): Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

   a. Indicate which view: ☐ 1 – AP ☐ 2 – PA ☐ 8 – UNK

   b. Indicate position: ☐ 1 – Supine ☐ 2 – Upright ☐ 8 – UNK

   c. Captured on inspiration? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

   d. Quality of image: ☐ 1 – Good ☐ 2 – Fair ☐ 3 – Poor / Uninterpretable ☐ 8 – UNK

4. Was a lateral view image taken? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK
(If No or UNK, go to Q5)

If Yes, insert specimen ID (barcode label): Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

   a. Indicate position: ☐ 1 – Supine ☐ 2 – Upright ☐ 8 – UNK

   b. Captured on inspiration? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

   c. Quality of image: ☐ 1 – Good ☐ 2 – Fair ☐ 3 – Poor / Uninterpretable ☐ 8 – UNK

5. Was a decubitus image taken? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK
(If No or UNK, go to Q6)

If Yes, insert specimen ID (barcode label): Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

   a. Captured on inspiration? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

   b. Quality of image: ☐ 1 – Good ☐ 2 – Fair ☐ 3 – Poor / Uninterpretable ☐ 8 – UNK

SITE LOGO

CRF 08: CASE CXR

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date of CXR: DAY MONTH YEAR

6. CXR interpretation *(mark all that apply)*:

- ☐ a. Normal
- ☐ b. Abscess
- ☐ c. Air bronchogram
- ☐ d. Alveolar infiltrate
- ☐ e. Atelectasis
- ☐ f. Bronchial thickening/peribroncial cuffing
- ☐ g. Cardiomegaly
- ☐ h. Consolidation

→ i. If checked, do the findings indicate eligibility for lung tap? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

1. If child is eligible for a lung tap, was the procedure done? ☐ 1 – YES ☐ 0 – NO

If No, reason not collected *(check all that apply):*

- ☐ Unknown
- ☐ Child met one or more clinical contraindications
- ☐ Parent/guardian refused
- ☐ Child died prior to collection of specimen
- ☐ Other, specify: _____ *Other code:* ☐☐☐

- ☐ i. Hyperinflation
- ☐ j. Interstital infiltrate
- ☐ k. Lymphadenopathy or mass
- ☐ l. Other abnormalities
- ☐ m. Pleural effusion
- ☐ n. Pneumatocoeles
- ☐ o. Pneumothorax
- ☐ p. Pulmonary edema
- ☐ q. Reticulonodular infiltrate
- ☐ r. Unknown / uninterpretable

SITE LOGO

CRF 08: CASE CXR

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date of CXR: DAY MONTH YEAR

Optional (For Sites Comparing Site Readings with PERCH Radiology Panel):

7. Is the film quality adequate: ☐ 1 – Adequate ☐ 2 – Suboptimal ☐ 3 – Poor / Uninterpretable ☐ 8 – UNK

8. Does the film contain significant pathology? ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

9. Primary end-point consolidation?
   Right: ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK
   Left: ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

10. Other consolidation/infiltrate?
   Right: ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK
   Left: ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

11. Pleural fluid?
   Right: ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK
   Left: ☐ 1 – YES ☐ 0 – NO ☐ 8 – UNK

12. Conclusion *(check one):*

- ☐ 1 – Primary end-point consolidation or pleural effusion
- ☐ 2 – Other consolidation/infiltrate
- ☐ 3 – No consolidation/infiltrate/effusion
- ☐ 4 – Uninterpretable

Comments:_____

_____

_____

Form Completed By: _____ ***Staff Code***:

Supervisor Signature: _____ ***Supervisor Staff Code***:

Supervisor Verification Date: ***Day*** ***Month*** ***Year***

SITE LOGO

CRF 09:
CASE SPECIMEN COLLECTION: LUNG ASPIRATE

PARTICIPANT ID

DATE LUNG ASPIRATE COLLECTED: DAY MONTH YEAR

1. At the initial assessment, does the child have any of the following contraindications to LA collection:

	1 - YES	0 - NO
a. Presence of pneumatocoeles on CXR: ……	☐	☐
b. Post measles pneumonia: ……	☐	☐
c. Patient determined clinically unstable by a clinician……	☐	☐
d. CPR performed within the last 24 hours……	☐	☐

If the answer to any of the above is Yes, do not collect a lung aspirate at this time.

Wait and evaluate the child again at a later point.

LUNG ASPIRATE

2. Time of lung aspirate collection: ☐☐☐☐ *(24 hour clock)*

3. Collection performed by: _____ *STAFF CODE:* ☐☐☐☐

4. Lung aspirate specimen ID (barcode label): Scan or affix barcode label: **9A** ☐☐☐☐☐☐ – ☐☐

Record the following clinical measures:

Time point	i. Oxygen requirement *(XX.X, L/min)* *(N/A if not on O_2)*	ii. Oxygen saturation *(%)*	iii. Respiratory Rate *(per minute)* and Haemoptysis	iv. Conscious Level *(check one)* A=Alert and awake V= Responds to voice P=Responds to pain U= Unresponsive PS= Pharmacologically sedated
A. Immediately prior to LA procedure ____:____	☐☐.☐ 8 – UNK ☐ 9 – N/A ☐	☐☐☐ 8 – UNK ☐ 9 – NR ☐	☐☐☐ 8 – UNK ☐ 9 - N/A ☐ Haemoptysis: Y ☐ N ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐
B. Immediately following LA procedure ____:____	☐☐.☐ 8 - UNK ☐ 9 – N/A ☐	☐☐☐ 8 - UNK ☐ 9 – NR ☐	☐☐☐ 8 – UNK ☐ 9 - N/A ☐ Haemoptysis: Y ☐ N ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐

SITE LOGO

CRF 09:
CASE SPECIMEN COLLECTION: LUNG ASPIRATE

PARTICIPANT ID

DATE LUNG ASPIRATE COLLECTED: DAY MONTH YEAR

Time point	i. Oxygen requirement *(XX.X, L/min)* *(N/A if not on O_2)*	ii. Oxygen saturation *(%)*	iii. Respiratory Rate *(per minute)* and Haemoptysis	iv. Conscious Level *(check one)* A=Alert and awake V= Responds to voice P=Responds to pain U= Unresponsive PS= Pharmacologically sedated
C. 15 minutes following LA procedure ____:____	. 8 - UNK ☐ 9 – N/A ☐	8 - UNK ☐ 9 – NR ☐	8 - UNK ☐ 9 - N/A ☐ Haemoptysis: Y ☐ N ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐
D. 30 minutes following LA procedure ____:____	. 8 - UNK ☐ 9 – N/A ☐	8 - UNK ☐ 9 – NR ☐	8 - UNK ☐ 9 - N/A ☐ Haemoptysis: Y ☐ N ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐
E. 2 hours after LA procedure ____:____	. 8 - UNK ☐ 9 – N/A ☐	8 - UNK ☐ 9 – NR ☐	8 - UNK ☐ 9 - N/A ☐ Haemoptysis: Y ☐ N ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐
F. 4 hours after LA procedure ____:____	. 8 - UNK ☐ 9 – N/A ☐	8 - UNK ☐ 9 – NR ☐	8 - UNK ☐ 9 - N/A ☐ Haemoptysis: Y ☐ N ☐	0 – A ☐ 1 – V ☐ 2 – P ☐ 3 – U ☐ 8 – UNK ☐ 9 - PS ☐

SITE LOGO

CRF 09:
CASE SPECIMEN COLLECTION: LUNG ASPIRATE

PARTICIPANT ID

DATE LUNG ASPIRATE COLLECTED: DAY MONTH YEAR

5. Safety Monitoring: Where any of the following observed <u>within four hours</u> following the lung aspirate procedure?	1 - Yes	0 - No	8 - Unk
a. Drop in oxygen saturation to below 92%, resulting in increased supply of supplemental oxygen for 10 minutes or more	☐	☐	☐
b. New onset of unconsciousness or prostration	☐	☐	☐
c. New requirement for bronchodilator or increased frequency of bronchodilator treatment	☐	☐	☐
d. Pneumothorax	☐	☐	☐
e. Significant haemoptysis (>5mls) at any time following lung aspirate, during the hospitalization	☐	☐	☐
f. Death during hospitalization	☐	☐	☐

If any response above is marked YES, notify the local safety monitor and complete CRF 16 (Case SAE).

Note: Beyond the first four hours of surveillance, if the child develops a pneumothorax or dies at any time during hospitalization, the event must be reported to the local safety monitor and CRF 16 (Case SAE) must be completed.

Comments: _____

_____

_____

Supervisor Signature: _____ ***STAFF CODE***

Day ***Month*** ***Year***

SITE LOGO

CRF 10:
CASE SPECIMEN COLLECTION: PLEURAL FLUID

PARTICIPANT ID

Specimen number:

Date specimen collected: DAY MONTH YEAR

1. Time of pleural fluid collection: *TIME (24 hour clock)* **8 - UNK**

2. Specimen collected by Staff Code:

3. Pleural fluid specimen ID (*barcode label)*:

Scan or affix barcode label:

Comments: _____

_____

_____

Supervisor Signature: _____ ***STAFF CODE***:

Day ***Month*** ***Year***

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 11:
CASE ADMISSION MEDICATIONS

PARTICIPANT ID

DATE FORM COMPLETED: DAY MONTH YEAR

1. Were antibiotics administered at the study hospital on the day of admission? 1-YES 0-NO 8-UNK

If Yes, check all that apply:	Administered	Mode of Administration: 1-ORAL	2-PARENTERAL	8-UNK
a. Penicillin	If checked →			
b. Amoxicillin (Ampicillin)	If checked →			
c. Amoxicillin/Clavulanate (Augmentin)	If checked →			
d. Cotrimoxazole (Bactrim, Septrin)	If checked →			
e. Cefuroxime (2nd gen. Cephalosporin)	If checked →			
f. Ceftriaxone (3rd gen. Cephalosporin)	If checked →			
g. Ganciclovir	If checked →			
h. Macrolide (Azithromycin, Erythromycin)	If checked →			
i. Aminoglycoside (Gentamicin)	If checked →			
j. Chloramphenicol	If checked →			
k. Ciprofloxacin (Quinolone)	If checked →			
l. Cloxacillin	If checked →			
m. Other antibiotic: _____	If checked →			

Other code:

n. Date and time first antibiotic was administered in the study hospital:

DAY *MONTH* *YEAR* 8-UNK *(24 hour clock)* 8-UNK

Was antibiotic administered before collection of each of the following specimens?

	1-YES	0-NO	8-UNK	9-N/A
o. Blood culture				
p. NPS-VTM, OPS, NPS-STGG				
q. Urine				
r. Induced sputum				

2. Was a medication to treat influenza administered on the day of admission? 1-YES 0-NO 8-UNK

If Yes, check all that apply:

a. Oseltamivir

b. Zanamivir

c. Other: *Specify*: _____ *Code:*

d. Date and time first influenza medication was administered:

DAY *MONTH* *YEAR* 8-UNK *(24 hour clock)* 8-UNK

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 11:
CASE ADMISSION MEDICATIONS

PARTICIPANT ID

DATE FORM COMPLETED: DAY MONTH YEAR

3. Were steroids administered on the day of admission? 1-YES 0-NO 8-UNK

   a. If Yes, specify type: 1-Oral 2-Inhaled 3-Intramuscular 4-Intravenous 8-UNK

   b. Date first dose of steroids was administered:

   DAY *MONTH* *YEAR*

4. Have bronchodilators been administered on the day of admission? 1-YES 0-NO 8-UNK
   (as part of bronchodilator challenge or otherwise)

5. Were medications to treat TB administered on the day of admission? 1-YES 0-NO 8-UNK

If Yes, check all that apply:	**Administered**	**Mode of Administration?** 1-ORAL	2-PARENTERAL	8-UNK
a. Fixed Drug Combinations	If checked →			
b. INH	If checked →			
c. Ethambutol	If checked →			
d. Rifampin	If checked →			
e. Pyrazinamide	If checked →			
f. Other medication: _____	If checked →			

Other code:

   g. Date first TB medication was administered:

   DAY *MONTH* *YEAR*

Comments:_____

_____

Form completed by: _____ ***STAFF CODE***:

Supervisor Signature: _____ ***STAFF CODE***:

Day *Month* *Year*

SITE LOGO

CRF 12:
CASE 24/48-HOUR FOLLOW-UP

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE FORM COMPLETED: DAY MONTH YEAR

Complete this form on each of the two days following admission.

1. Check which post-admission assessment is being performed: ☐ 1 - 24 hours ☐ 2 - 48 hours
2. Time of assessment: …… ☐☐☐☐ *(24 hour clock)*
3. Location of assessment:

   ☐ 1 - Hospital ☐ 2 - Clinic ☐ 3 - Home

4. Temperature…….. ☐☐.☐ °C ☐1- Axillary ☐2- Rectal 8-UNK ☐
5. Respiratory rate (# of breaths counted in 60 seconds): …… ☐☐☐ *per minute* 8-UNK ☐ 9 - N/A ☐
6. Is child on O_2? *(if No or UNK, skip to Q7)*…….. 1-YES ☐ 0-NO ☐ 8-UNK ☐

   a. If Yes, oxygen delivery flow rate:…… ☐☐.☐ L/min 8-UNK ☐

7. Is child receiving mechanical ventilation?..... 1-YES ☐ 0-NO ☐ 8-UNK ☐
8. Pulse oximetry (*on room air whenever possible*): ……..…… ☐☐☐ % 8-UNK ☐

   b. Measured when child was on:

☐	1 - O_2
☐	2 - Room air
☐	8 - UNK

SITE LOGO

CRF 12:
CASE 24/48-HOUR FOLLOW-UP

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE FORM COMPLETED: DAY MONTH YEAR

CLINICAL STATUS

9. On exam today, does the child have any of the following signs?

Signs:	1-YES	0-NO	8-UNK
a. Lower chest wall indrawing	☐	☐	☐
b. Head nodding	☐	☐	☐
c. Central cyanosis	☐	☐	☐
d. Unable to feed	☐	☐	☐
e. Vomiting everything	☐	☐	☐
f. Lethargy, or unconsciousness	☐	☐	☐

Assessment of consciousness level: If V, P or U are ticked, the child has lethargy or impaired consciousness.

NOTE: wait for >30 minutes after any convulsion before carrying out assessment of consciousness level.

- ☐ 0-A: Alert & awake
- ☐ 1-V: responds to Voice
- ☐ 2-P: responds to Pain
- ☐ 3-U: Unresponsive
- ☐ 8-UNK
- ☐ 9 - Pharmacologically sedated

10. Did the child have convulsions since the last assessment?..... 1-YES ☐ 0-NO ☐ 8-UNK ☐

a. If Yes, what kind (*check all that apply*)

☐ Multiple *(≥2 episodes)* ☐ Prolonged *(≥15 minutes)* ☐ Single brief *(<15 minutes)*

11. What is the WHO pneumonia severity classification?

☐	1 - Very severe
☐	2 - Severe
☐	3 - Neither
☐	8 - UNK

SITE LOGO

CRF 12:
CASE 24/48-HOUR FOLLOW-UP

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE FORM COMPLETED: DAY MONTH YEAR

MEDICATION

12. Has any additional medication for treatment of wheeze been administered since enrollment (other than any bronchodilator challenge doses administered at enrollment)? (*If No or UNK, skip to Q13)*…….. 1-YES ☐ 0-NO ☐ 8-UNK ☐

13. Which antibiotics is the child currently on, including medication added during this assessment? *(check all that apply)*

Antibiotic:		Mode of administration? 1-ORAL	2-PARENTERAL	8-UNK
a. ☐ Penicillin	If checked, →	☐	☐	☐
b. ☐ Amoxicillin (ampicillin)	If checked, →	☐	☐	☐
c. ☐ Amoxicillin & Clavulonate (Augmentin)	If checked, →	☐	☐	☐
d. ☐ Cotrimoxizole (Bactrim, Septrin)	If checked, →	☐	☐	☐
e. ☐ Cefuroxime (2nd gen. Cephalosporin)	If checked, →	☐	☐	☐
f. ☐ Ceftriaxone (3rd gen. Cephalosporin)	If checked, →	☐	☐	☐
g. ☐ Macrolide (Azithromycin, Erythromycin)	If checked, →	☐	☐	☐
h. ☐ Aminoglycoside (Gentamicin)	If checked, →	☐	☐	☐
i. ☐ Cloxacillin	If checked, →	☐	☐	☐
j. ☐ Chloramphenicol	If checked, →	☐	☐	☐
k. ☐ Ganciclvir	If checked, →	☐	☐	☐
l. ☐ Any Quinolone (specify: _____) ☐☐☐	If checked, →	☐	☐	☐
m. ☐ Other antibiotic: _____	If checked, →	☐	☐	☐

Other code: ☐☐☐

14. If antibiotics were changed since last assessment, specify why:

☐	01 - New findings on CXR
☐	02 - Changed to oral antibiotics
☐	03 - Changed because of diagnostic test result
☐	04 - Allergic reaction to medication
☐	05 - Not responding to initial therapy
☐	06 - Stock (out of initial antibiotics)
☐	08 - Unknown
☐	09-N/A
☐	99-Other, specify: _____ *Code:* ☐☐☐

SITE LOGO

CRF 12:
CASE 24/48-HOUR FOLLOW-UP

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE FORM COMPLETED: DAY MONTH YEAR

15. Was a medication to treat influenza (e.g. oseltamavir) added since the last assessment? 1-YES ☐ 0-NO ☐ 8-UNK ☐

16. Since admission (or last assessment) has the child been started on medication to treat or prevent PCP? 1-YES ☐ 0-NO ☐ 8-UNK ☐

(If Yes, answer questions below ; if No or UNK, skip to Q17)

Why started?

a. Why started? ☐ 1 - PCP preventive therapy *(if checked,answer Q16b, skip Q16c and proceed to Q17)*
☐ 2 - PCP treatment *(if checked, answer both Q16b and Q16c)*

b. ☐ Cotrimoxazole (Septrin, Bactrim) If checked, →
- ☐ 01-Clinical suspicion of PCP
- ☐ 02-Lab test results suggest PCP
- ☐ 03-Newly recognized risk factor, e.g. HIV
- ☐ 04-Prevention of PCP
- ☐ 08-UNK
- ☐ 99-Other

Other specify: _____ *Code:* ☐☐☐

c. ☐ Corticosteroids If checked, →
- ☐ 01-Clinical suspicion of PCP
- ☐ 02-Lab test results suggest PCP
- ☐ 03-Newly recognized risk factor, e.g. HIV
- ☐ 08-UNK
- ☐ 99-Other

Other specify: _____ *Code:* ☐☐☐

17. Have any TB meds been started since the last assessment?..... 1-YES ☐ 0-NO ☐ 8-UNK ☐

a. If Yes, why started? *(check all that apply)*
- ☐ UNK
- ☐ Contact history
- ☐ CXR
- ☐ Clinical suspicion
- ☐ TB skin test → i. What is the TST result? ☐☐ mm
- ☐ Diagnostic test
- ☐ Other *specify:* _____ *Code:* ☐☐☐

Comments: _____

_____

Form completed by: _____ ***STAFF CODE:*** ☐☐☐☐

Supervisor Signature: _____ ***STAFF CODE:*** ☐☐☐☐

☐☐ Day ☐☐☐ Month ☐☐☐☐ Year

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 13:
CASE DISCHARGE

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

1. Date of discharge: DAY MONTH YEAR

2. Discharge status *(check one):*

- ☐ 1 - Discharged home: not moribund
- ☐ 2 - Discharged home: moribund
- ☐ 3 - Left against medical advice: not moribund
- ☐ 4 - Left against medical advice: moribund
- ☐ 5 - Died (skip to Q5 and complete CRF 17 Case Mortality)
- ☐ 6 - Transferred (if transferred, complete Q2a)

a. Reason for transfer?

- ☐ 01 - For higher level facility
- ☐ 02 - To be closer to home
- ☐ 03 - Convalescent care for patient in moribund state (i.e, lower level facility)
- ☐ 08 - UNK
- ☐ 99 - Other, specify: _____ Code*:*

3. Respiratory rate (*# of breaths counted in 60 seconds):* *per minute* 8 - UNK ☐ 9 - N/A ☐

4. Pulse oximetry (*on room air whenever possible - record from digit)*: % 8 - UNK ☐

5. Were antibiotics changed since last assessment? 1 -YES ☐ 0 - NO ☐ 8 - UNK ☐

a. If Yes, why? *(Check all that apply)*

- ☐ New findings on CXR
- ☐ Not responding to initial therapy
- ☐ Change from IV to PO medication
- ☐ Allergic reaction to med
- ☐ Stock-out of initial antibiotics
- ☐ Other, specify: _____ Code*:*

6. Was medication to treat influenza (e.g., oseltamavir) added since last assessment? 1 -YES ☐ 0 - NO ☐ 8 - UNK ☐

7. Were any TB meds started since last assessment? 1 -YES ☐ 0 - NO ☐ 8 - UNK ☐

a. If Yes, why? *(Check all that apply)* 8 - UNK ☐

- ☐ Contact history
- ☐ CXR finding
- ☐ Clinical suspicion
- ☐ TB skin test If checked → i. What is the TST result? *mm* 8 - UNK ☐
- ☐ Diagnostic test
- ☐ Other, specify: _____ Code:

SITE LOGO

CRF 13:
CASE DISCHARGE

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

8. Since last assessment has the child been started on medication to treat or prevent PCP? 1-YES 0-NO 8-UNK

If Yes, answer questions below; if No or UNK, skip to Q9)

a. Why started?
- ☐ 1 - PCP preventive therapy *(if checked,answer Q8b, skip Q8c and proceed to Q9)*
- ☐ 2 - PCP treatment *(if checked, answer both Q8b and Q8c)*

b. ☐ Cotrimoxazole (Septrin, Bactrim) If checked, → **Why started?**
- ☐ 01-Clinical suspicion of PCP
- ☐ 02-Lab test results suggest PCP
- ☐ 03-Newly recognized risk factor, e.g. HIV
- ☐ 04-Prevention of PCP
- ☐ 08-UNK
- ☐ 99-Other

Other specify: _____ *Code:* ☐☐☐

c. ☐ Corticosteroids If checked, →
- ☐ 01-Clinical suspicion of PCP
- ☐ 02-Lab test results suggest PCP
- ☐ 03-Newly recognized risk factor, e.g. HIV
- ☐ 08-UNK
- ☐ 99-Other

Other specify: _____ *Code:* ☐☐☐

SITE LOGO

CRF 13:
CASE DISCHARGE

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

9. Discharge diagnoses *(check all that apply)*: 8 - UNK ☐

- ☐ Pneumonia
- ☐ Bronchiolitis (Acute)
- ☐ Lower respiratory tract infection
- ☐ Afebrile seizure disorder
- ☐ Anaemia – cause unknown
- ☐ Anaemic heart failure
- ☐ Asthma (Acute)
- ☐ Birth asphyxia
- ☐ Cellulitis
- ☐ Cerebral palsy
- ☐ Congenital heart disease *(clinically suspected or echo-diagnosed)*
- ☐ Congenital abnormality *(excluding congenital heart disease)*
- ☐ Diarrhoeal disease (Acute)
- ☐ Dysentery
- ☐ Empyema thoracis
- ☐ Epilepsy
- ☐ Failure to thrive
- ☐ Febrile convulsion (Acute)
- ☐ Gastroenteritis
- ☐ Helminthiasis
- ☐ HIV
- ☐ Immunosuppression
- ☐ Malaria
- ☐ Malnutrition
- ☐ Meningitis
- ☐ Mucocutaneous candidiasis
- ☐ Neonatal sepsis
- ☐ Osteomyelitis (Acute)
- ☐ Otitis media
- ☐ PCP Pneumonia
- ☐ Pneumothorax - primary and secondary
- ☐ Poisoning
- ☐ Prematurity
- ☐ Protein energy malnutrition
- ☐ Pulmonary TB
- ☐ Septic arthritis
- ☐ Septicaemia
- ☐ Sickle cell anaemia
- ☐ Sickle cell disease
- ☐ Skin sepsis
- ☐ Urinary tract infection
- ☐ Upper respiratory tract infection

- ☐ Other: _____ *Code:* ☐☐☐☐
- ☐ Other: _____ *Code:* ☐☐☐☐
- ☐ Other: _____ *Code:* ☐☐☐☐

SITE LOGO

CRF 13:
CASE DISCHARGE

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date form completed: DAY MONTH YEAR

10. All other concurrent conditions *(check all that apply):* 8 - UNK 9 - NONE

- ☐ Pneumonia
- ☐ Bronchiolitis (Acute)
- ☐ Lower respiratory tract infection
- ☐ Afebrile seizure disorder
- ☐ Anaemia – cause unknown
- ☐ Anaemic heart failure
- ☐ Asthma (Acute)
- ☐ Birth asphyxia
- ☐ Cellulitis
- ☐ Cerebral palsy
- ☐ Congenital heart disease *(clinically suspected or echo-diagnosed)*
- ☐ Congenital abnormality *(excluding congenital heart disease)*
- ☐ Diarrhoeal disease (Acute)
- ☐ Dysentery
- ☐ Empyema thoracis
- ☐ Epilepsy
- ☐ Failure to thrive
- ☐ Febrile convulsion (Acute)
- ☐ Gastroenteritis
- ☐ Helminthiasis
- ☐ HIV
- ☐ Immunosuppression
- ☐ Malaria
- ☐ Malnutrition
- ☐ Meningitis
- ☐ Mucocutaneous candidiasis
- ☐ Neonatal sepsis
- ☐ Osteomyelitis (Acute)
- ☐ Otitis media
- ☐ PCP Pneumonia
- ☐ Pneumothorax - primary and secondary
- ☐ Poisoning
- ☐ Prematurity
- ☐ Protein energy malnutrition
- ☐ Pulmonary TB
- ☐ Septic arthritis
- ☐ Septicaemia
- ☐ Sickle cell anaemia
- ☐ Sickle cell disease
- ☐ Skin sepsis
- ☐ Urinary tract infection
- ☐ Upper respiratory tract infection

- ☐ Other: _____ Code:
- ☐ Other: _____ Code:
- ☐ Other: _____ Code:

Comments: _____

_____

Form Completed by: _____ ***STAFF CODE:***

Supervisor Signature: _____ ***STAFF CODE:***

Supervisor Verification Date: *Day* *Month* *Year*

SITE LOGO

CRF 14:
CASE 30-DAY FOLLOW-UP AND CONVALESCENT BLOOD

PARTICIPANT ID

Date of follow-up: DAY MONTH YEAR

NOTE: This form does not need to be completed if the child died prior to discharge.

1. Was a follow-up interview conducted? ☐ 1 – Yes ☐ 0 - No

   At least two attempts must be made to contact the patient. A phone interview is only acceptable if an in person visit is not possible.

   a. If Yes, location of follow-up:

☐	01 - Facility
☐	02 - By phone
☐	03 - At child's home
☐	08 - UNK
☐	99 - Other, specify: _____ Code:

   b. If No, provide reason for no follow-up interview:

☐	01 - Child out-migrated or moved to unknown address
☐	02 - Child travelled out of study area
☐	03 - Parent refused
☐	04 - Unable to locate child during follow-up period
☐	05 - Child died after discharge
☐	08 - UNK
☐	99 - Other, specify: _____ Code:

2. Who was interviewed? *(check all that apply)*

☐	Unknown
☐	Mother
☐	Father
☐	Caregiver (non-parent)
☐	Other relative or household member (non-caregiver)
☐	Neighbor
☐	Other, specify: _____ Code:

3. Child's vital status:

☐	1 - Living
☐	2 - Deceased
☐	8 - UNK

4. Was child observed? *(If No, skip to end and sign form)* ☐ 1 – Yes ☐ 0 – No ☐ 8 - UNK

SITE LOGO

PERCH Pneumonia Etiology Research for Child Health

CRF 14:
CASE 30-DAY FOLLOW-UP AND CONVALESCENT BLOOD

PARTICIPANT ID

Date of follow-up: DAY MONTH YEAR

5. Height/length: ___.___ *cm* 8 - UNK ☐

6. Weight: ___.___ *kg* 8 - UNK ☐

7. Mid upper arm circumference (MUAC) *(N/A for children <3 months old)*_: ___ *mm* 8 - UNK ☐ 9 – N/A ☐

8. Respiratory rate (*# of breaths counted in 60 seconds)*: ___ *per minute* 8 - UNK ☐ 9 - N/A ☐

9. If in facility, pulse oximetry (*on room air whenever possible; record from digit):* ___ % 8 - UNK ☐ 9 – N/A ☐

10. Was convalescent blood collected? *(plain/red top tube - collect 4mL; minimum 2mL)*

☐ 1 – Yes ☐ 0 – No ☐ 8 - UNK

If Yes, complete Q10 a-c and fill out CRF 19

If No, complete Q10d

a. Date of blood collection: ___ ***Day*** ___ ***Month*** ___ ***Year***

b. Time of blood collection: ___ *(24 hour clock)*

c. Blood specimen ID (barcode label): Scan or affix barcode label: ___ – ___

d. Reason why not?

☐ 01 - Parent refused

☐ 02 - Phlebotomist unable to collect blood

☐ 08 - UNK

☐ 99 - Other, specify: _____ Code: ___

Question 11 is For HIV-positive cases only: *(i.e., HIV-negative)*

11. Was EDTA blood obtained for CD4 testing? 1 – YES ☐ 0 - NO ☐ 8 – UNK ☐ 9 – N/A ☐

If Yes, complete Q11a and fill out CRF 19.

If No, complete Q11 b.

a. EDTA blood specimen ID (barcode label): Scan or affix barcode label: ___ – ___

b. Reason why not?

☐ 01 - Parent refused

☐ 02 - CD4 count obtained from Patient Support Center/ART Treatment Clinic

☐ 08 - UNK

☐ 99 - Other, specify: _____ Code: ___

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 14:
CASE 30-DAY FOLLOW-UP AND CONVALESCENT BLOOD

PARTICIPANT ID

Date of follow-up: DAY MONTH YEAR

12. Was a urine sample collected? ☐ 1 – Yes ☐ 0 – No ☐ 8 - UNK

If Yes, complete Q12a-d and fill out CRF 19

If No, complete Q12e

a. Date of urine collection: ***Day*** ***Month*** ***Year***

b. Time of urine collection: *(24 hour clock)*

c. Urine specimen ID (barcode label): Scan or affix barcode label: –

d. Container collected in:

☐	1 - Sterile cup
☐	2 - Urine bag

e. Reason why not?

☐ 01 - Parent refused

☐ 02 - Child did not void

☐ 08 - UNK

☐ 99 - Other, specify: _____ Code:

Comments: _____

_____

Collection Performed By: _____ ***Staff Code***:

Supervisor Staff Code:

Supervisor Verification Date: ***Day*** ***Month*** ***Year***

Form Completed By: _____ ***Staff Code***:

Day ***Month*** ***Year***

SITE LOGO

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

PARTICIPANT ID

DATE OF LUNG BIOPSY: DAY MONTH YEAR

☐ **Please check this box which confirms that a consent form was signed for the lung biopsy**

PERCUTANEOUS NEEDLE BIOPSY

1. Time of postmortem lung biopsy or pleural aspiration: ☐☐☐☐ *(24 hour clock)* **8 - UNK** ☐

2. Death-biopsy (or aspiration) interval in hours: ☐☐ **8 - UNK** ☐

3. Procedure performed by Staff Code: ☐☐☐☐

4. Was at least one lung biopsy successfully collected? ☐ 1 -Yes ☐ 0 - No
   (If Yes, skip to Q 6 If No, complete questions 5 a-b below and then end form.)

5. Only if unable to take any core biopsies (Q4 is No), attempt pleural aspiration. If antemortem chest x-ray was done, target aspiration from any effusion if present, or area of consolidation.

   Was pleural fluid/aspirate taken from:

   a. Right Lung: ☐ 1 - Yes ☐ 0 - No
   ☐☐☐☐☐☐ P R

   b. Left Lung: ☐ 1 - Yes ☐ 0 - No
   Insert barcode number or label:
   ☐☐☐☐☐☐ – P L

6. What was the site of disease as diagnosed by clinical exam and chest x-ray?

☐	1 - Localised (lobar pneumonia)
☐	2 - Diffuse disease
☐	8 - Unknown

(If 1 – Localised is selected complete Q7. If 2 – Diffuse disease or 8 – Unknown is selected, skip to Q8.)

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

						DATE OF LUNG BIOPSY:									

PARTICIPANT ID — DAY — MONTH — YEAR

7. Sampling Protocol for **Localised (Lobar) Pneumonia**: (*To minimize contamination, please collect the samples in the order specified below)*

Note: if collection difficult, prioritise 1 sample for microbiology, 1 sample for histology and 1 sample to be stored in RNA later as indicated by underlining below (Sample types b,e,g):

a) Site(s) of Disease *(check all that apply)*	☐ Right Upper Lobe (RUL)	☐ Right Middle Lower (RML)	☐ Right Lower Lobe (RLL)	☐ Left Upper Lobe (LUL)	☐ Left Lower Lobe (LLL)

Sample Type	Tube	Specimen ID (scan barcode label):
b) Microbiology core from **a diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M1**	Insert barcode number or label: ☐☐☐☐☐☐ – M 1
c) Microbiology core from **a diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M2**	Insert barcode number or label: ☐☐☐☐☐☐ – M 2
d) Microbiology core from **a diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M3**	Insert barcode number or label: ☐☐☐☐☐☐ – M 3
e) RNAlater sample from **a diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R7**	Insert barcode number or label: ☐☐☐☐☐☐ – R 7
f) RNAlater sample from **a diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R8**	Insert barcode number or label: ☐☐☐☐☐☐ – R 8

SITE LOGO

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

PARTICIPANT ID

DATE OF LUNG BIOPSY: DAY MONTH YEAR

Sample Type	Tube	Specimen ID (scan barcode label):
g) Histology core from a **diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H11**	Insert barcode number or label: ____ – H 1 1
h) Histology core from a **diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H12**	Insert barcode number or label: ____ – H 1 2
i) Histology core from **non-diseased lobe of diseased lung** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H13**	Insert barcode number or label: ____ – H 1 3
j) Frozen tissue core from a **diseased lobe** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube F16**	Insert barcode number or label: ____ – F 1 6
k) Microbiology core from **non-diseased lung** (If right lung is diseased, take core from LUL; if left lung is diseased, take core from RUL) Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M4**	Insert barcode number or label: ____ – M 4
l) Microbiology core from **non-diseased lung** (If right lung is diseased, take core from LUL; if left lung is diseased, take core from RUL) Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M5**	Insert barcode number or label: ____ – M 5

SITE LOGO

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

PARTICIPANT ID

DATE OF LUNG BIOPSY: DAY MONTH YEAR

Sample Type	Tube	Specimen ID (scan barcode label):
m) Microbiology core from **non-diseased lung** (If right lung is diseased, take core from LUL; if left lung is diseased, take core from RUL) Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M6**	Insert barcode number or label: ____ – M 6
n) RNAlater sample from **non-diseased lung** (If right lung is diseased, take core from LUL; if left lung is diseased, take core from RUL) Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R9**	Insert barcode number or label: ____ – R 9
o) RNAlater sample from **non-diseased lung** (If right lung is diseased, take core from LUL; if left lung is diseased, take core from RUL) Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R10**	Insert barcode number or label: ____ – R 1 0
p) Histology core from **non-diseased lung** (If right lung is diseased, take core from LUL; if left lung is diseased, take core from RUL) Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H14**	Insert barcode number or label: ____ – H 1 4

SITE LOGO

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

PARTICIPANT ID

DATE OF LUNG BIOPSY: DAY MONTH YEAR

Sample Type	Tube	Specimen ID (scan barcode label):
q) Histology core from **non-diseased lung** (If right lung is diseased, take core from LUL; if left lung is diseased, take core from RUL) Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H15**	Insert barcode number or label: _____ – H 1 5

8. Sampling protocol for **Diffuse Disease** OR if the site of disease (Q6) is **Unknown**: *(To minimize contamination, please collect the samples in the order specified below)*

Note: if collection difficult, prioritise 1 sample for microbiology, 1 sample for histology and 1 sample to be stored in RNAlater as indicated by underlining below (Sample types a,d,f):

Sample Type	Tube	Specimen ID (scan barcode label):
a) Microbiology core from **RUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M1**	Insert barcode number or label: _____ – M 1
b) Microbiology core from **RLL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M2**	Insert barcode number or label: _____ – M 2
c) Microbiology core from **RUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M3**	Insert barcode number or label: _____ – M 3

SITE LOGO

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

PARTICIPANT ID

DATE OF LUNG BIOPSY: DAY MONTH YEAR

Sample Type	Tube	Specimen ID (scan barcode label):
d) RNAlater sample from **RUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R7**	Insert barcode number or label: ____ – R 7
e) RNAlater sample from **RLL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R8**	Insert barcode number or label: ____ – R 8
f) Histology core from **RUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H11**	Insert barcode number or label: ____ – H 1 1
g) Histology core from **RML** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H12**	Insert barcode number or label: ____ – H 1 2
h) Histology core from **RLL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H13**	Insert barcode number or label: ____ – H 1 3
i) Frozen tissue core from **RUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube F16**	Insert barcode number or label: ____ – F 1 6

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

PARTICIPANT ID

DATE OF LUNG BIOPSY: DAY MONTH YEAR

Sample Type	Tube	Specimen ID (scan barcode label):
j) Microbiology core from **LUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M4**	Insert barcode number or label: _____ – M 4
k) Microbiology core from **LLL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M5**	Insert barcode number or label: _____ – M 5
l) Microbiology core from **LUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube M6**	Insert barcode number or label: _____ – M 6
m) RNAlater core from **LUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R9**	Insert barcode number or label: _____ – R 9
n) RNAlater core from **LLL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube R10**	Insert barcode number or label: _____ – R 1 0
o) Histology core from **LUL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H14**	Insert barcode number or label: _____ – H 1 4
p) Histology core from **LLL** Core collected? ☐ 1 – Yes ☐ 0 - No	**Tube H15**	Insert barcode number or label: _____ – H 1 5

SITE LOGO

CRF 15:
CASE SPECIMEN COLLECTION: POST-MORTEM LUNG BIOPSY

						DATE OF LUNG BIOPSY:									

PARTICIPANT ID — DAY — MONTH — YEAR

Comments:_____

_____

_____

_____

_____

Supervisor Signature: _____ ***STAFF CODE***:

Day ***Month*** ***Year***

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 16:
CASE SERIOUS ADVERSE EVENT

PARTICIPANT ID

SAE event number for this child: ☐☐ (xx)

1. Date of SAE: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

2. Date of birth: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

3. Is this the initial or final report of this SAE? ☐ 1 – Initial ☐ 2 – Final
(The final report must have "Final" selected.)

4. Time of SAE onset: ☐☐☐☐ *(24 HR)* ☐ 8 - UNK

5. Did the child have a lung aspirate or was there an attempt to collect this specimen? ☐ 1 - Yes ☐ 0 - No
   a. If Yes, date/time: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR ☐☐☐☐ TIME (24 HR)

6. Did the child have induced sputum collected or was there an attempt to collect this specimen? ☐ 1 - Yes ☐ 0 - No
   a. If Yes, date/time: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR ☐☐☐☐ TIME (24 HR)

7. Specify event and any complications *(check all that apply)*:

Event Description	During the severe pneumonia episode:	Within 4 hrs after lung aspirate:	Within 4 hrs after induced sputum:
a. Death related to PERCH procedures	☐	☐	☐
b. Drop in oxygen saturation below 92%, resulting in increased supply of supplemental oxygen for 10 minutes or more	☐	☐	☐
c. New onset of unconsciousness or prostration	☐	☐	☐
d. New requirement for bronchodilators or increased frequency of bronchodilator treatment	☐	☐	☐
e. Pneumothorax at any time following lung aspirate, during the hospitalization	☐	☐	☐
f. Significant haemoptysis (> 5 mLs) at any time following lung aspirate, during the hospitalization	☐	☐	☐
g. Other, specify:_____ _____ *Code:* ☐☐☐☐	☐	☐	☐

SITE LOGO

CRF 16:
CASE SERIOUS ADVERSE EVENT

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

SAE event number for this child: | | | (xx)

8. Relatedness to study procedure:
(N/A if study procedure not done)

a. SAE relatedness to lung aspirate:

☐	1 - Definitely related
☐	2 - Probably related
☐	3 - Possibly related
☐	4 - Probably not related/unlikely
☐	5 - Definitely not related

☐ 9 – N/A

b. SAE relatedness to induced sputum:

☐	1 - Definitely related
☐	2 - Probably related
☐	3 - Possibly related
☐	4 - Probably not related/unlikely
☐	5 - Definitely not related

☐ 9 - N/A

c. SAE relatedness to other study procedure:

☐	1 - Definitely related
☐	2 - Probably related
☐	3 - Possibly related
☐	4 - Probably not related/unlikely
☐	5 - Definitely not related

☐ 9 - N/A

i. Specify other study procedure: _____

Code: | | | | |

d. If Definitely not related, specify probable cause: _____

Code: | | | | |

9. SAE Severity:

☐	1 - Mild
☐	2 - Moderate
☐	3 - Severe

SITE LOGO

CRF 16:
CASE SERIOUS ADVERSE EVENT

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

SAE event number for this child: | | | (xx)

10. SAE outcome at initial reporting: *(check one)*

- ☐ 1 - Resolved
- ☐ 2 - Resolved with sequelae *(explain in comments)*
- ☐ 3 - Continuing *(explain in comments)*
- ☐ 4 - Death
- ☐ 8 – Unknown

Date of death/ Date resolved: | | | | | | | | |

DAY ***MONTH*** ***YEAR***

11. Is the child continuing to participate in the PERCH study? ☐ 1 - Yes ☐ 0 - No

12. Clinical narrative of SAE: _____

SITE LOGO

CRF 16:
CASE SERIOUS ADVERSE EVENT

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

SAE event number for this child: | | | (xx)

ALL SAEs MUST BE FOLLOWED TO RESOLUTION. IF NOT RESOLVED, REASSESS THE SAE UNTIL FINAL RESOLUTION.

13. Final SAE outcome (if different from the initial SAE outcome in Q10): *(check one)*

- ☐ 1 - Resolved
- ☐ 2 - Resolved with sequelae *(explain in comments)*
- ☐ 3 - Continuing *(explain in comments)*
- ☐ 4 – Death
- ☐ 8 - Unknown

Date of death/ Date resolved: | | | DAY | | | MONTH | | | | YEAR

14. SAE final comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Form Completed By: _____ | | | | | Staffcode

Local Safety Monitor: _____ | | | | | Staffcode

Supervisor Signature: _____ | | | | | Staffcode

Verification Date: | | | DAY | | | MONTH | | | | YEAR

SITE LOGO

CRF 17:
CASE MORTALITY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE OF DEATH: DAY MONTH YEAR

1. Did the child die at the **study facility**? 1 - YES 0 - NO 8 - UNK
   If Yes, complete Section A. If No or UNK, skip to Section B.

   a. If Yes, where did the child die? ☐ 1 – Kamalapur ☐ 2 – Dhaka Hospital

Section A. Complete this section for deaths that occurred <u>at the study facility</u>.

2. Time of death: ☐☐☐☐ ***(24 hour clock)*** Time 8-UNK ☐
3. Indicate the immediate cause of death from the medical record *(check one)*: 8 - UNK ☐

   ☐ 01 - Pneumonia
   ☐ 02 - Gastorenteritis
   ☐ 03 - Malaria
   ☐ 04 - Dehydration/shock
   ☐ 05 - Meningitis
   ☐ 06 - Malnutrition
   ☐ 07 - HIV
   ☐ 09 - Sepsis (any cause)
   ☐ 99 - Other, specify:_____ Code: ☐☐☐☐

4. Indicate other causes of death listed on the medical record *(check all that apply):* 8 - UNK ☐ 9 - NONE ☐

   ☐ Pneumonia
   ☐ Gastorenteritis
   ☐ Malaria
   ☐ Dehydration/shock
   ☐ Meningitis
   ☐ Malnutrition
   ☐ HIV
   ☐ Sepsis (any cause)
   ☐ Other, specify _____ Code: ☐☐☐☐

PERCUTANEOUS LUNG BIOPSY CONSENT

5. Did parent/caregiver give consent for a post-mortem lung biopsy? 8 - UNK ☐

   ☐ 1 - Yes → *If Yes, complete CRF 15 CASE SPECIMEN COLLECTION: LUNG BIOPSY.*
   ☐ 0 - No → If No, what is parent/caregiver's reason for refusing consent?

   _____
   _____
   _____

   ☐ 2 - Consent not sought

SITE LOGO

CRF 17:
CASE MORTALITY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE OF DEATH: DAY MONTH YEAR

Section B. Complete this section for deaths that were <u>not known</u> to occur at the study facility.

6. Where did the child die? **8-UNK** ☐

☐	01 - Other facility, specify: _____ Code:
☐	02 - Home
☐	99 - Other, specify: _____ Code:

7. Is a death certificate available? **1-YES** ☐ **0-NO** ☐ **8-UNK** ☐

If Yes, answer Q7a and Q7b, then skip to end. If No or Unk, skip to Q8.

a. Immediate cause of death *(check one)*: **8-UNK** ☐

- ☐ 01 - Pneumonia
- ☐ 02 - Gastorenteritis
- ☐ 03 - Malaria
- ☐ 04 - Dehydration/shock
- ☐ 05 - Meningitis
- ☐ 06 - Malnutrition
- ☐ 07 - HIV
- ☐ 09 - Sepsis (any cause)
- ☐ 99 - Other, specify:_____ Code:

b. Other causes of death *(check all that apply)* : **8 - UNK** ☐ **9 - NONE** ☐

- ☐ Pneumonia
- ☐ Gastorenteritis
- ☐ Malaria
- ☐ Dehydration/shock
- ☐ Meningitis
- ☐ Malnutrition
- ☐ HIV
- ☐ Sepsis (any cause)
- ☐ Other, specify:_____ Code:

SITE LOGO

CRF 17:
CASE MORTALITY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE OF DEATH: DAY MONTH YEAR

***(Section B continued.** Post-discharge Deaths.)*

If No death certificate is available (or UNK), answer Q8.

8. Was the family interviewed regarding the cause of death? 1-YES 0-NO 8-UNK

If Yes, ask the parent/caregiver Q8a and Q8b. If No or Unk, skip to Q9.

a. What did the doctor or nurse say was the cause of death?*(check all that apply)* 9-N/A 8-UNK

- ☐ Pneumonia
- ☐ Gastorenteritis
- ☐ Malaria
- ☐ Dehydration/shock
- ☐ Meningitis
- ☐ Malnutrition
- ☐ HIV
- ☐ Sepsis (any cause)
- ☐ Other,specify:_____ Code:
- ☐ Other, specify:_____ Code:
- ☐ Other,specify:_____ Code:

b. What do you think is the cause of death? *(check all that apply)* 8-UNK

- ☐ Pneumonia
- ☐ Gastorenteritis
- ☐ Malaria
- ☐ Dehydration/shock
- ☐ Meningitis
- ☐ Malnutrition
- ☐ HIV
- ☐ Sepsis (any cause)
- ☐ Other, specify:_____ Code:
- ☐ Other, specify:_____ Code:
- ☐ Other, specify:_____ Code:

SITE LOGO

CRF 17:
CASE MORTALITY

PERCH Pneumonia Etiology Research for Child Health

PARTICIPANT ID

DATE OF DEATH: DAY MONTH YEAR

***(Section B continued.** Post-discharge Deaths.)*

If No death certificate is available (or UNK), answer Q9.

9. Is cause of death available from another source? **1-YES** **0-NO** **8-UNK**

If Yes, answer Q9a-c. If No or UNK, skip to end.

a. Source *(check one)* : **08-UNK**

- ☐ 01 - Medical record *(from other non-study facility)*
- ☐ 02 - Verbal autopsy
- ☐ 99 - Other,specify_____ Code:

b. Immediate cause of death *(check one)* : **08-UNK**

- ☐ 01 - Pneumonia
- ☐ 02 - Gastorenteritis
- ☐ 03 - Malaria
- ☐ 04 - Dehydration/shock
- ☐ 05 - Meningitis
- ☐ 06 - Malnutrition
- ☐ 07 - HIV
- ☐ 09 - Sepsis (any cause)
- ☐ 99 - Other, specify:_____ Code:

c. Other causes of death *(check all that apply):* **8 - UNK** **9 - NONE**

- ☐ Pneumonia
- ☐ Gastorenteritis
- ☐ Malaria
- ☐ Dehydration/shock
- ☐ Meningitis
- ☐ Malnutrition
- ☐ HIV
- ☐ Sepsis (any cause)
- ☐ Other, specify_____ Code:

Comments:

_____

_____

_____

_____

Interviewer's Name: _____ ***STAFF CODE***:

Supervisor Signature: _____ ***STAFF CODE***:

Day ***Month*** ***Year***

SITE LOGO

CRF 18:
STUDY TERMINATION

PERCH
Pneumonia Etiology Research for Child Health

PARTICIPANT ID

Date of termination DAY MONTH YEAR

This form should be completed for all children who terminate the PERCH study early. Complete this form when their participation has ended. This form should be completed only once for each child.

1. Did the child complete all applicable study protocol assessments? ☐ 1 – YES ☐ 0 - NO

   a. If No, indicate the reason(s) the child terminated the study early: *(check all that apply)*

☐	Primary caregiver withdrew consent
☐	Died
☐	Failure to comply with study regulations
☐	Moved from the area
☐	Could not locate for follow up
☐	Other, specify: _____ *Code:*
☐	8 - UNK

Comments: _____

_____

Form completed by: _____ **Staff code**:

Supervisor signature: _____ **Staff code**:

Supervisor verification date: **Day** **Month** **Year**

SITE LOGO

CRF 19:
LAB: SPECIMEN RECEPTION

DATE SPECIMEN RECEIVED ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

1. Specimen ID (barcode label): Scan or Affix Barcode Label ☐☐☐☐☐☐ – ☐☐

2. Specimen Type (check **one**):

☐	1A - Blood Culture Bottle	☐	2A - 30 Day Follow up Plain Tube	☐	6A - Gastric Aspirate
☐	1B - Plain/ Red Top Tube	☐	2B - 30 Day Follow up EDTA (CD4)	☐	6B - Second Gastric Aspirate
☐	1C - EDTA *case* tube #1	☐	3A - NP STGG Swab	☐	6C - Third Gastric Aspirate
☐	1D - EDTA *case* tube #2	☐	3B - NP VTM and OP Swab	☐	7A - Urine
☐	1E - EDTA *control* tube #1	☐	3B - NP VTM Swab ONLY	☐	7B - 30 Day Follow up Urine
☐	1F - EDTA *control* tube #2	☐	3B - OP Swab ONLY	☐	8A - Pleural Fluid
		☐	4A - Induced Sputum	☐	8B - Second Pleural Fluid
☐	1H - Malaria Slide	☐	4B - Second Induced Sputum	☐	9A - Lung Aspirate
☐	1I - HIV Rapid Test	☐	5A - ETT Specimen	☐	6D - Fourth Gastric Aspirate
☐	1J - Dried Blood Spot	☐	5B - Second ETT Specimen	☐	6E - Fifth Gastric Aspirate

3. Time received in laboratory: ☐☐☐☐
TIME (24 hour clock)

4. Specimen volume: ☐☐☐☐☐ µl ☐ N/A (for blood culture, dried blood spot, NP/OP swabs, and slides only)

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 19:
LAB: SPECIMEN RECEPTION

DATE SPECIMEN RECEIVED ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

5. Status: ☐ Accepted for processing

☐ Rejected – specify reason below (check all that apply):

Contact clinic immediately if any apply.

- ☐ a. Specimen unlabeled
- ☐ b. Specimen ID does not match ID on requisition form
- ☐ c. Blood is hemolyzed or anti-coagulated specimen contains clots
- ☐ d. Specimen container is leaking
- ☐ e. Other, specify: _____ ☐☐☐ *CODE*

6. Was specimen transported under appropriate conditions and time frame?

☐ Yes ☐ No ☐ UNK

7. Person Receiving Specimen Staff Code: ☐☐☐☐

Comments: _____

_____

_____

Supervisor Staff Code: ☐☐☐☐

Supervisor Verification Date: ☐☐ *Day* ☐☐☐ *Month* ☐☐☐☐ *Year*

SITE LOGO

CRF 19PM:
LAB: SPECIMEN RECEPTION – POST-MORTEM SPECIMENS

DATE SPECIMEN RECEIVED | DAY | MONTH | YEAR

1. Specimen ID (barcode label): Scan or Affix Barcode Label –

2. Specimen Type (check **one**):

☐	M1 – Microbiology Core 1	☐	H11 – Histology Core 1
☐	M2 – Microbiology Core 2	☐	H12 – Histology Core 2
☐	M3 – Microbiology Core 3	☐	H13 – Histology Core 3
☐	M4 – Microbiology Core 4	☐	H14 – Histology Core 4
☐	M5 – Microbiology Core 5	☐	H15 – Histology Core 5
☐	M6 – Microbiology Core 6	☐	F16 – Frozen Tissue Sample
☐	R7 – RNAlater Sample 1	☐	PR – Pleural Aspirate – Right Lung
☐	R8 – RNAlater Sample 2	☐	PL – Pleural Apsirate – Left Lung
☐	R9– RNAlater Sample 3		
☐	R10 – RNAlater Sample 4		

3. Time received in laboratory:
TIME (24 hour clock)

4. Specimen volume: **µl**

Volume should be recorded for the pleural aspirates only.

SITE LOGO

CRF 19PM:
LAB: SPECIMEN RECEPTION – POST-MORTEM SPECIMENS

DATE SPECIMEN RECEIVED ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

5. Status: ☐ 1 - Accepted for processing

☐ 2 - Rejected – specify reason below (check all that apply):

Contact study personnel immediately if any apply

☐ a. Specimen unlabeled
☐ b. Specimen ID does not match ID on requisition form
☐ c. Specimen container is leaking
☐ d. Other, specify: _____ ☐☐☐ ***CODE***

6. Was specimen transported under appropriate conditions and time frame?

☐ 1 - Yes ☐ 0 - No ☐ 8 - UNK

7. Person Receiving Specimen Staff Code: ☐☐☐☐

Comments: _____

_____

_____

Supervisor Staff Code: ☐☐☐☐

Supervisor Verification Date: ☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

CRF 19OTH:
OTHER LAB: RECEPTION

DATE SPECIMEN RECEIVED ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

1. Specimen ID (barcode label): Scan or Affix Barcode Label ☐☐☐☐☐☐ – ☐☐

2. Other Specimen Type:

   Other, specify: _____ Code: ☐☐☐

3. Time received in laboratory: ☐☐☐☐
   TIME (24 hour clock)

4. Specimen volume: ☐☐☐☐ µl ☐ N/A

5. Status: ☐ Accepted for processing
   ☐ Rejected – specify reason below (check all that apply):

Contact clinic immediately if any apply.

- ☐ a. Specimen unlabeled
- ☐ b. Specimen ID does not match ID on requisition form
- ☐ c. Blood is hemolyzed or anti-coagulated specimen contains clots
- ☐ d. Specimen container is leaking
- ☐ e. Other, specify: _____ ☐☐☐ *CODE*

6. Was specimen transported under appropriate conditions and time frame?
   ☐ Yes ☐ No ☐ UNK

Comments: _____

_____

_____

7. ***Person Receiving Specimen Staff Code***: ☐☐☐☐

Supervisor Staff Code: ☐☐☐☐

Supervisor Verification Date: ☐☐ ☐☐☐ ☐☐☐☐

SITE LOGO

CRF 20:
LAB RESULT: BLOOD CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

1. Specimen ID (barcode label): Scan / Affix barcode label: ____ ____ ____ ____ ____ ____ – ____ ____

NOT DONE:
Stop here and end form

2. a. Date/time the blood culture bottle was placed in BACTEC / BacT/ALERT:

DAY *MONTH* *YEAR* *TIME (24 hour clock)*

b. Technician's Staff Code: ____ ____ ____ ____

3. Sample volume:
   a. Weight of bottle prior to specimen collection: ____ ____ ____ . ____ ____ grams
   b. Weight of bottle after collection / at time of reception in lab: ____ ____ ____ . ____ ____ grams

4. Results reporting:
   a. Alarm positive? ☐ 1 - YES ☐ 0 – NO, negative at 5 days *(stop here and end form)*

5. Time to positive (from blood culture machine): ____ ____ ____ . ____ hrs

6. Description of any organism by Gram stain of blood culture broth *(check all that apply)*:

Gram stain performed: ☐ 1 - YES ☐ 0 - NO

a.	No organisms seen	☐
b.	Gram-negative rods (GNR)	☐
c.	Gram-positive cocci in clusters (GPC clusters)	☐
d.	Gram-negative coccobacilli (GNCB)	☐
e.	Gram-positive cocci in chains (GPC chains)	☐
f.	Gram-negative diplococci (GNDC)	☐
g.	Gram-positive cocci single cells (GPC singles)	☐
h.	Gram-negative cocci (GNC)	☐
i.	Gram-positive rods (GPR)	☐
j.	Gram-positive diplococci (GPDC)	☐
k.	Yeasts or other fungal elements	☐

SITE LOGO

CRF 20:
LAB RESULT: BLOOD CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

Reminder: Binax result should be performed only on samples that are:

- *BACTEC or BacT/ALERT alarm positive, gram stain negative, and sub-culture negative (no growth on 24 hour plates)*

  -or-

- *BACTEC or BacT/ALERT alarm positive, streptococci positive on gram stain, and sub-culture negative (no growth on 24 hour plates)*

7. Binax result *(check one)*: ☐ 1- Positive ☐ 2 – Negative ☐ 3 – Indeterminate ☐ 9 - Not done

8. Description of sub-culture growth results: ☐ 1 - Growth ☐ 2 - No growth
   (If no growth, stop here and end form.)

9. Organism identification:

Organism Code	**Isolate ID (barcode label)** N/A ONLY if organism is a contaminant	**Organism Confirmation** C - Confirmed U - Updated NC - Not Confirmed
a. Organism 1	Scan/Affix Barcode Label 9 – N/A ☐	☐ 1 - C ☐ 2 - U ☐ 3 - NC
b. Organism 2	Scan/Affix Barcode Label 9 – N/A ☐	☐ 1 - C ☐ 2 - U ☐ 3 - NC
c. Organism 3	Scan/Affix Barcode Label 9 – N/A ☐	☐ 1 - C ☐ 2 - U ☐ 3 - NC

SITE LOGO

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Pneumonia Etiology Research for Child Health

CRF 20:
LAB RESULT: BLOOD CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

10. Antibiotic Susceptibility Testing:
Note: **1: S = Susceptible; 2: I = Intermediate; 3: R = Resistant**

	Organism 1		Organism 2		Organism 3	
Antibiotic code:	**Zone of inhibition in mm (xx):**	**S / I / R Code:**	**Zone of inhibition in mm (xx):**	**S / I / R Code:**	**Zone of inhibition in mm (xx):**	**S / I / R Code:**
a. AMC (Amoxicillin / Clavulanic acid)						
b. AMP (Ampicillin)						
c. CAZ (Ceftazidimine)						
d. CH (Chloramphenicol)						
e. CIP (Ciprofloxacin)						
f. CN (Gentamicin)						
g. CRO (Ceftriaxone)						
h. CTX (Cefotaxime)						
i. DA (Clindamycin)						
j. ERY (Erythromycin)						
k. FOX (Cefoxitin)						
l. IPM (Imipenem)						
m. OX (Oxacillin)						
n. P (Penicillin)						
o. SXT (Cotrimoxazole)						
p. TET (Tetracycline)						
q. VA (Vancomycin)						
r. Other:_____ Code:						
s. Other:_____ Code:						
t. Other:_____ Code:						
u. Beta lactamase	1 - Positive 2 - Negative		1 - Positive 2 - Negative		1 - Positive 2 - Negative	

SITE LOGO

CRF 20:
LAB RESULT: BLOOD CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

11. MIC Etest® results for *S. pneumoniae* isolates that are resistant (R) or intermediate (I) to oxacillin disk diffusion testing.

MIC Etest® performed? ☐ 1 - YES ☐ 0 – No ☐ 9 – N/A (*If No or N/A, skip to Question 12)*

a. Penicillin Etest® results ☐ < ☐ > ☐☐.☐☐☐ *µg/mL*

b. ☐ Ceftriaxone or ☐ Cefotaxime (choose one) ☐ < ☐ > ☐☐.☐☐☐ *µg/mL*

c. Clindamycin Dtest® results ☐ 1- Positive ☐ 2 – Negative

12. Screening for Extended Spectrum β-Lactamase (ESBL) Production done?

☐ 1 – YES ☐ 0 - NO

a. If Yes, results of additional phenotypic testing:

☐ 1 - ESBL confirmed ☐ 2 - ESBL not confirmed

13. MIC Etest® results for *S. aureus* isolates that are resistant (R) or intermediate (I) to cefoxitin disk diffusion testing.

MIC Etest® performed? ☐ 1 - YES ☐ 0 – No ☐ 9 – N/A

a. Vancomycin Etest® results ☐ < ☐ > ☐☐.☐☐☐ *µg/mL*

b. Clindamycin Dtest® results ☐ 1- Positive ☐ 2 – Negative

14. Was *S. pneumoniae* isolated?

☐ 1 – YES ☐ 0 – NO

If Yes, what serotypes were identified:

a. ☐☐☐☐☐☐☐☐☐☐

b. ☐☐☐☐☐☐☐☐☐☐

c. ☐☐☐☐☐☐☐☐☐☐

d. ☐☐☐☐☐☐☐☐☐☐

SITE LOGO

CRF 20:
LAB RESULT: BLOOD CULTURE

						DATE FORM INITIATED:									

PARTICIPANT ID DAY MONTH YEAR

15. Was *H. influenza* isolated?

☐ 1 – YES ☐ 0 – NO

If Yes, what serotype was identified:

a. | | | | |

Comments:

_____

_____

Technician Reporting Final Results Staff Code: | | | | |

Supervisor Staff Code: | | | | |

Supervisor Verification Date: | | | | | | | | | |

Day ***Month*** ***Year***

SITE LOGO

CRF 21:
LAB RESULT: PNEUMOCOCCAL PCR

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

NOT DONE:
Stop here and end form
☐

Scan or Affix Barcode Label:
☐☐☐☐☐☐ – ☐☐

1. Nucleic acid extract aliquot ID (barcode label):

2. Date of nucleic acid extraction: ☐☐ ***DAY*** ☐☐☐ ***MONTH*** ☐☐☐☐ ***YEAR***

3. Volume of blood extracted: ☐☐☐ µL

4. Technician who performed extraction : ☐☐☐☐ **STAFF CODE**

5. Date of PCR run: ☐☐ ***DAY*** ☐☐☐ ***MONTH*** ☐☐☐☐ ***YEAR***

6. Technician who performed PCR run : ☐☐☐☐ **STAFF CODE**

Comments: _____

_____

_____

Supervisor Staff Code: ☐☐☐☐

Supervisor Verification Date: ☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

CRF 22:
LAB RESULT: ANTIBIOTIC ACTIVITY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

NOT DONE:
Stop here and end form ☐

Specimen type (*check one*):

☐ 1- Serum

☐ 2 - Urine

1. Specimen ID *(Scan or affix barcode label)*: ☐☐☐☐☐☐ – ☐☐

2. Technician's Staff Code: ☐☐☐☐

3. Date result was read: ☐☐ ***DAY*** ☐☐☐ ***MONTH*** ☐☐☐☐ ***YEAR***

4. Diameter of zone of inhibition: ☐☐ *mm*

Comments: _____

_____

_____

Supervisor Signature: _____ ***STAFF CODE***: ☐☐☐☐

☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

CRF 23:
LAB RESULT: CORE BLOOD TESTS

CBC

NOT DONE:
Skip to next section ☐

South Africa only - Date and time received in laboratory:

☐☐ ☐☐☐ ☐☐☐☐ ☐☐☐☐

DAY *MONTH* *YEAR* *TIME (24 hour clock)*

1. Date of test: ☐☐ ☐☐☐ ☐☐☐☐

DAY *MONTH* *YEAR*

2. Specimen ID (barcode label): Scan or Affix Barcode Label ☐☐☐☐☐☐ – ☐☐

3. Technician's Staff Code: ☐☐☐☐

4. CBC Results

				Controls:	
	Variable:	**Result:**	**Units:**	**Result:**	**Units:**
a.	Hemoglobin	☐☐.☐	g/dL	☐☐.☐	g/dL N/A ☐
b.	Hematocrit	☐☐.☐	%		
c.	MCV	☐☐☐.☐	fL		
d.	MCH	☐☐.☐	Pg		
e.	MPV	☐☐.☐	fL		
f.	Platelets	☐☐☐☐	$x10^3/\mu L$		
g.	WBC	☐☐☐.☐	$x10^3/\mu L$		
h.	Neutrophils	☐☐.☐	%		
i.	Lymphocytes	☐☐.☐	%		
j.	Monocytes	☐☐.☐	%		
k.	Eosinophils	☐☐.☐	%		
l.	Basophils	☐☐.☐	%		
m.	Band Cells	☐☐.☐	%		
n.	RBC	☐.☐☐	$x10^6/\mu L$		
o.	MCHC	☐☐☐.☐☐	g/dL		
p.	Reticulocytes	☐☐.☐	%		

SITE LOGO

CRF 23:
LAB RESULT: CORE BLOOD TESTS

HIV ANTIBODY TEST

NOT DONE:
If applicable, indicate reason not done and then skip to next section ☐

If HIV antibody test not done, indicate the reason why:

☐ 1 – Child known to be positive ☐ 2 – Testing was refused ☐ 9 – Other

Other, specify: _____ Other code: ☐☐☐☐

5. Date of test: ☐☐ ☐☐☐ ☐☐☐☐
   DAY *MONTH* *YEAR*

6. Specimen ID (barcode label): Scan or Affix Barcode Label: ☐☐☐☐☐☐☐–☐☐ **Same as Above** ☐

7. Technician's name: _____ Staff Code: ☐☐☐☐

8. HIV antibody test final result: ☐ 1 - Positive ☐ 2 - Negative ☐ 3 – Indeterminate ☐ 4 - Invalid

   a. If positive, is the child <18 months old? ☐ 1 - Yes ☐ 0 - No
   (If Yes, HIV PCR test should be done.)

HIV PCR TEST

NOT DONE:
Skip to next section ☐

(for HIV antibody-positive children less than 18 months old)

9. Date of test: ☐☐ ☐☐☐ ☐☐☐☐
   DAY *MONTH* *YEAR*

10. PCR test result: ☐ 1 - Positive ☐ 2 - Negative

11. Technician's Staff Code: ☐☐☐☐

CD4 TEST

NOT DONE:
Skip to Q15 ☐

12. Date of test: ☐☐ ☐☐☐ ☐☐☐☐
    DAY *MONTH* *YEAR*

13. CD4 test result:

    a. Absolute count: ☐☐☐☐ cells/µL ☐ 9 - Not done

    b. CD4 percent: ☐☐.☐☐ % ☐ 9 - Not done

14. Technician's Staff Code: ☐☐☐☐

SITE LOGO

CRF 23:
LAB RESULT: CORE BLOOD TESTS

SICKLE CELL TEST [THALASSEMIA TESTING for Thailand]

15. Date of test: ☐☐ ☐☐☐ ☐☐☐☐ *DAY* *MONTH* *YEAR*

16. Specimen ID (barcode label): Scan or Affix Barcode Label: ☐☐☐☐☐☐–☐☐ **Same as Above** ☐

17. Technician's Staff Code: ☐☐☐☐

18. a. Solubility testing results

☐ 1 – Positive ☐ 2 - Negative ☐ 9 - N/A

b. Test result / HB type: *(check one)* 09 – N/A ☐

☐ 01 - AA ☐ 02 -AF ☐ 03 -AS ☐ 04 -EA ☐ 05 -EF ☐ 06 - SC

☐ 07 -SS ☐ 08 - A_2A ☐ 10 - EE ☐ 11 - EFA ☐ 12 - C A_2A H ☐ 13 -A_2F

☐ 14 -A_2FA ☐ 15 - A_2A H ☐ 16- AE Barts ☐ 17- AC ☐ 99 – Other, specify

Other, specify: _____ Other code: ☐☐☐

c. Hemoglobin Fractions

A ☐☐.☐ % ☐ 9 – N/A F ☐☐.☐ % ☐ 9 – N/A

A2 ☐☐.☐ % ☐ 9 – N/A Cs ☐☐.☐ % ☐ 9 – N/A

E ☐☐.☐ % ☐ 9 – N/A H ☐☐.☐ % ☐ 9 – N/A

MALARIA TESTING

NOT DONE: Skip to next section ☐

19. Date of test: ☐☐ ☐☐☐ ☐☐☐☐ *DAY* *MONTH* *YEAR*

20. Specimen ID (barcode label): Scan or Affix Barcode Label ☐☐☐☐☐☐–☐☐

21. Technician's Staff Code: ☐☐☐☐

SITE LOGO

CRF 23:
LAB RESULT: CORE BLOOD TESTS

22. Type of Test (check one. If both tests were done, check the one that was done first.):

☐ 1 – Rapid Antigen Detection ☐ 2 - Microscopy

a. Test result: ☐ 1 – Positive ☐ 2 - Negative

23. a: If Positive, species ☐ Speciation not done, skip to next section

	1 - Yes	0 - No
i. *P. falciparum*	☐	☐
ii. *P. vivax*	☐	☐
iii. *P. ovale*	☐	☐
iv. *P. malariae*	☐	☐

b: Quantification ☐ 9 – Not done

i. Parasitaemia ☐☐☐☐ ☐ 1 - per 200 WBC ☐ 2 - per 500 WBC

ii. Density ☐☐☐☐☐☐ /µL ☐ 1 - using white cell count ☐ 2 - using red blood cell count

CRP TESTING

NOT DONE: End Form ☐

24. Date of test: ☐☐ ☐☐☐ ☐☐☐☐
DAY *MONTH* *YEAR*

25. Specimen ID (barcode label): Scan or Affix Barcode Label ☐☐☐☐☐☐–☐☐ **Same as Above** ☐

26. Technician's Staff Code: ☐☐☐☐

27. Test result: ☐☐☐.☐☐ mg/L

30 DAY FOLLOW-UP CD4 TEST

28. Date of test: ☐☐ ☐☐☐ ☐☐☐☐
DAY *MONTH* *YEAR*

29. CD4 test result:

a. Absolute count: ☐☐☐☐ cells/µL ☐ 9 - Not done

b. CD4 percent: ☐☐.☐☐ % ☐ 9 - Not done

SITE LOGO

CRF 23:
LAB RESULT: CORE BLOOD TESTS

30. Technician's Staff Code: | | | | |

Comments:_____

_____

_____

Supervisor Staff Code: | | | | | | | | | | | | | | | |

Day ***Month*** ***Year***

SITE LOGO

CRF 24:
LAB RESULT: NP CULTURE

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DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

1. Specimen ID:
2. Date / time put up for culture: ☐☐ *DAY* ☐☐☐ *MONTH* ☐☐☐☐ *YEAR* ☐☐☐☐ *TIME (24 hour clock)*

Identification of pneumococcal colonies	**a. If yes, optochin zone diameter (mm):**	**b. Bile soluble? *(only do if optochin zone is 9-13mm)***	**Serotype *(skip if not yet available)***	**c. Isolate ID (barcode label):**
3. Was a pneumococcal colony identified? *(if no, end form)* ☐ Yes ☐ No	☐☐	☐ Yes ☐ No ☐ Not done	_____	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
4. Was a second pneumococcal colony identified? *(if no, end form)* ☐ Yes ☐ No	☐☐	☐ Yes ☐ No ☐ Not done	_____	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
5. Was a third pneumococcal colony identified? *(if no, end form)* ☐ Yes ☐ No	☐☐	☐ Yes ☐ No ☐ Not done	_____	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐
6. Was a fourth pneumococcal colony identified? *(if no, end form)* ☐ Yes ☐ No	☐☐	☐ Yes ☐ No ☐ Not done	_____	Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

Comments: _____

_____

_____

***Supervisor STAFF CODE*:** ☐☐☐☐ **DAY** ☐☐ **MONTH** ☐☐☐ **YEAR** ☐☐☐☐

SITE LOGO

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CRF 25:
LAB RESULT: MULTIPLEX PCR

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

Specimen number: ☐☐

NOT DONE:
Stop here and end form ☐

1. Date of nucleic acid extraction: ☐☐ *DAY* ☐☐☐ *MONTH* ☐☐☐☐ *YEAR*

2. Nuceic acid extract aliquot ID:

Scan or affix barcode label:
☐☐☐☐☐☐ – ☐☐

3. Technician who performed extraction: ☐☐☐☐ *STAFF CODE*

4. Specimen type *(check one)*:

- ☐ 01- NP flocked swab/OP swab
- ☐ 02 - Induced sputum
- ☐ 03 - Lung aspirate
- ☐ 04 - NP flocked swab only
- ☐ 05 - ETT aspirate
- ☐ 07 - OP swab only
- ☐ 08 - Pleural fluid
- ☐ 09 - M2: Microbiology Core 2
- ☐ 10 - M5: Microbiology Core 5
- ☐ 11 - PR: Pleural Aspirate Right Lung
- ☐ 12 - PL: Pleural Aspirate Left Lung

5. Date of PCR Run: ☐☐ *DAY* ☐☐☐ *MONTH* ☐☐☐☐ *YEAR*

NOT DONE:
Stop here and end form ☐

6. Technician who performed run Staff Code*:* ☐☐☐☐

Comments: _____

_____

_____

***Supervisor Staff Code*:** ☐☐☐☐

☐☐ *Day* ☐☐☐ *Month* ☐☐☐☐ *Year*

SITE LOGO

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CRF 26:
LAB RESULT: INDUCED SPUTUM MICRO-CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

Quality Assessment and Gram Stain

1. a. Date: DAY MONTH YEAR b. Time: TIME (24 HR)

2. Specimen ID (barcode label): Scan or affix barcode label: –

NOT DONE: Stop here and end form ☐

3. Specimen type:

☐ 1 - Induced sputum ☐ 2 - ETT aspirate

4. Technician's Staff Code:

5. Number of neutrophils per representative low powered field (x10 objective)? *(check one)*

1 - <10 ☐
2 - 10-25 ☐
3 - >25 ☐

6. Mucus seen? *(check one)*

1 - Yes ☐
0 - No ☐

7. Number of epithelial cells per representative low powered field (x10 objective)? *(check one)*

1 - <10 ☐
2 - 10-25 ☐
3 - >25 ☐

Induced Sputum Gram Stain

8. Description of any organism by Gram stain:

Check the appropriate quantification box for Q8a-j below.

If no organisms were seen, check here and skip to Q9: ☐ No organisms seen (NOS)

	Organism	Not Seen	Scanty	1+	2+	3+
a.	Gram-negative rods (GNR)	☐	☐	☐	☐	☐
b.	Gram-positive cocci in clusters (GPC clusters)	☐	☐	☐	☐	☐
c.	Gram-negative coccobacilli (GNCB)	☐	☐	☐	☐	☐
d.	Gram-positive cocci in chains (GPC chains)	☐	☐	☐	☐	☐
e.	Gram-negative diplococci (GNDC)	☐	☐	☐	☐	☐
f.	Gram-positive cocci single cells (GPC singles)	☐	☐	☐	☐	☐
g.	Gram-negative cocci (GNC)	☐	☐	☐	☐	☐
h.	Gram-positive rods (GPR)	☐	☐	☐	☐	☐
i.	Gram-positive diplococci (GPDC)	☐	☐	☐	☐	☐
j.	Yeasts or other fungal elements	☐	☐	☐	☐	☐

SITE LOGO

PERCH Pneumonia Etiology Research for Child Health

CRF 26:
LAB RESULT: INDUCED SPUTUM MICRO-CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

Culture of Induced Sputum

9. Date/time put up for culture: DAY MONTH YEAR (24 hour clock)

10. Technician's Staff Code:

11. Final culture result: ☐ 1 - Growth (proceed) ☐ 2 - No growth (Stop here and end form)

12. Organism identification and quantification:

Organism Code	***Quantity (Select One)***	**Isolate ID (barcode label):**	**Organism Confirmation (*Check one*):** C – Confirmed U – Updated NC – Not Confirmed
a. Oropharyngeal flora	☐ 4 - Scanty ☐ 1+ ☐ 2+ ☐ 3+ ☐ 0 - None	N/A	
b. Organism 1	☐ 4 - Scanty ☐ 1+ ☐ 2+ ☐ 3+	Scan or affix barcode label: –	☐ 1: C ☐ 2: U ☐ 3: NC
c. Organism 2	☐ 4 - Scanty ☐ 1+ ☐ 2+ ☐ 3+	Scan or affix barcode label: –	☐ 1: C ☐ 2: U ☐ 3: NC
d. Organism 3	☐ 4 - Scanty ☐ 1+ ☐ 2+ ☐ 3+	Scan or affix barcode label: –	☐ 1: C ☐ 2: U ☐ 3: NC
e. Organism 4	☐ 4 - Scanty ☐ 1+ ☐ 2+ ☐ 3+	Scan or affix barcode label: –	☐ 1: C ☐ 2: U ☐ 3: NC

SITE LOGO

PERCH Pneumonia Etiology Research for Child Health

CRF 26:
LAB RESULT: INDUCED SPUTUM MICRO-CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

13. Antibiotic Susceptibility Testing:

Note: **1: S = Susceptible; 2: I = Intermediate; 3: R = Resistant**

	Organism 1		Organism 2		Organism 3		Organism 4	
Antibiotic Code:	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**
a. AMC (Amoxicillin / Clavulanic acid)								
b. AMP (Amplicillin)								
c. CAZ (Ceftazidimine)								
d. CH (Chloramphenicol)								
e. CIP (Ciprofloxacin)								
f. CN (Gentamicin)								
g. CRO (Ceftriaxone)								
h. CTX (Cefotaxime)								
i. DA (Clindamycin)								
j. ERY (Erythromycin)								
k. FOX (Cefoxitin)								
l. IPM (Imipenem)								
m. OX (Oxacillin)								
n. P (Penicillin)								
o. SXT (Cotrimoxazole)								
p. TET (Tetracycline)								
q. VA (Vancomycin)								
r. Other: _____ Code:								
s. Other: _____ Code:								
t. Other: _____ Code:								
u. Beta lactamase	1 - Positive 2 - Negative		1 - Positive 2 - Negative		1 - Positive 2 - Negative		1 - Positive 2 - Negative	

SITE LOGO

CRF 26:
LAB RESULT: INDUCED SPUTUM MICRO-CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

14. MIC Etest® results for *S. pneumoniae* isolates that are resistant (R) or intermediate (I) to oxacillin disk diffusion testing.

MIC Etest® performed? ☐ 1 - Yes ☐ 0 - No ☐ 9 - N/A (*If No or N/A, skip to Question 15)*

a. Penicillin Etest® results: ☐ < ☐ > ☐☐ . ☐☐☐ *µg/mL*

b. Ceftriaxone ☐ or Cefotaxime ☐ (choose one) ☐ < ☐ > ☐☐ . ☐☐☐ *µg/mL*

15. Screening for Extended Spectrum β-Lactamase (ESBL) Production done?

☐ 1 - Yes ☐ 0 - No

a. If Yes, results of additional phenotypic testing:

☐ 1 - ESBL confirmed ☐ 2 - ESBL not confirmed

16. Was *S. pneumoniae* isolated?

☐ 1 – Yes ☐ 0 – No

If Yes, what serotypes were identified:

a. ☐☐☐☐☐☐☐☐☐☐

b. ☐☐☐☐☐☐☐☐☐☐

c. ☐☐☐☐☐☐☐☐☐☐

d. ☐☐☐☐☐☐☐☐☐☐

17. Was *H. influenza* isolated?

☐ 1 - Yes ☐ 0 - No

If Yes, what serotype was identified:

a. ☐☐☐☐

SITE LOGO

CRF 26:
LAB RESULT: INDUCED SPUTUM MICRO-CULTURE

PARTICIPANT ID

DATE FORM INITIATED: DAY MONTH YEAR

Comments:

_____

_____

Technician Reporting Final Results Staff Code:

Supervisor Staff Code:

Supervisor Verification Date:

Day ***Month*** ***Year***

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 27:
LAB RESULT: TB TESTING

Date form initiated: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

Specimen type *(select one)*:

- ☐ 01 - Initial induced sputum
- ☐ 02- Pleural fluid
- ☐ 03 - Gastric aspirate
- ☐ 04 - ETT specimen
- ☐ 05 - Lung aspirate
- ☐ 07 - Second induced sputum
- ☐ 08 - Second pleural fluid
- ☐ 09 - Second gastric aspirate
- ☐ 10 - Second ETT specimen
- ☐ 11 - Third gastric aspirate
- ☐ 12 - Fourth gastric aspirate
- ☐ 13 - Fifth gastric aspirate
- ☐ 14 - M3: Microbiology Core 3
- ☐ 15 - M6: Microbiology Core 6
- ☐ 16 - PR: Pleural Aspirate Right Lung
- ☐ 17 - PL: Pleural Aspirate Left Lung

1. Date tested or sent to reference lab: ☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

2. Specimen ID (scan barcode label): Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

3. Technician's staff code: ☐☐☐☐

4. Volume of specimen sent for TB staining and culture: ☐☐☐☐☐ µL

ACID-FAST BACILLI SMEAR

5. Results *(select one)*:

☐	1 – Negative	No AFB per 100 oil immersion fields
☐	2 – Scanty	1-9 AFB per 100 oil immersion fields --- If Scanty, enter # of AFB ☐
☐	3 – Positive 1+	10-99 AFB per 100 oil immersion fields
☐	4 – Positive 2+	1-10 AFB per oil immersion field
☐	5 – Positive 3+	>10 AFB per oil immersion field
☐	6 – Not Done	Microscopy not done

CULTURE ☐ Culture not done *(skip to end)*

6. Mycobacterium tuberculosis isolated? ☐ 1 - Yes ☐ 0 – No ☐ 2 –Contaminated specimen

7. Other mycobacterium isolated? ☐ 1 - Yes ☐ 0 - No ☐ 2 –Contaminated specimen

a - b. If Yes, enter the following information:

Organism Code	
a. ☐☐☐☐	Specimen ID (scan or affix barcode label): ☐☐☐☐☐☐ – ☐☐
b. ☐☐☐☐	Specimen ID (scan or affix barcode label): ☐☐☐☐☐☐ – ☐☐

SITE LOGO

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Pneumonia Etiology Research for Child Health

CRF 27:
LAB RESULT: TB TESTING

Date form initiated: DAY | MONTH | YEAR

8. Susceptibility testing:
Note: **1: S = Susceptible; 2: I = Intermediate; 3: R = Resistant**

		Mycobacterium tuberculosis	Organism A	Organism B
	Antibiotic	S / I /R Code:	S / I /R Code:	S / I /R Code:
a.	Isoniazid:			
b.	Pyrazinamide:			
c.	Ethambutol:			
d.	Amikacin:			
e.	Capreomycin:			
f.	Ethionamide:			
g.	Rifampicin:			
h.	Streptomycin:			
i.	Ofloxacin:			
j.	Kanamycin:			
k.	Cycloserine:			
l.	PAS:			
m.	Other: _____ Code:			
n.	Other: _____ Code:			
o.	Other: _____ Code:			

Comments: _____

_____

_____

Supervisor Staff Code:

Supervisor Verification Date: *Day* | *Month* | *Year*

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 28:
LAB RESULT: PLEURAL FLUID - LUNG ASPIRATE

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

NOT DONE:
Stop here and end form ☐

Specimen number: ☐☐

1. Date/time put up for culture: ☐☐ *DAY* ☐☐☐ *MONTH* ☐☐☐☐ *YEAR* ☐☐☐☐ *TIME (24 hour clock)*

Scan or affix barcode label:

2. Specimen ID (barcode label): ☐☐☐☐☐☐ – ☐☐
3. Specimen type *(check one)*:
   - ☐ 1 - Pleural fluid
   - ☐ 2 - Lung aspirate

   3a. If pleural fluid, select all that apply: ☐ purulent ☐ bloody ☐ clear
4. Technician's Staff Code:

Gram Stain

5. Description of any organism by Gram stain:
   Check the appropriate quantification box for Q5a-j below.
   If no organisms were seen, check here and skip to Q6: ☐ No organisms seen (NOS)

SITE LOGO

CRF 28:
LAB RESULT: PLEURAL FLUID - LUNG ASPIRATE

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

	Organism	Not Seen	Scanty	1+	2+	3+
a.	Gram-negative rods (GNR)	☐	☐	☐	☐	☐
b.	Gram-positive cocci in clusters (GPC clusters)	☐	☐	☐	☐	☐
c.	Gram-negative coccobacilli (GNCB)	☐	☐	☐	☐	☐
d.	Gram-positive cocci in chains (GPC chains)	☐	☐	☐	☐	☐
e.	Gram-negative diplococci (GNDC)	☐	☐	☐	☐	☐
f.	Gram-positive cocci single cells (GPC singles)	☐	☐	☐	☐	☐
g.	Gram-negative cocci (GNC)	☐	☐	☐	☐	☐
h.	Gram-positive rods (GPR)	☐	☐	☐	☐	☐
i.	Gram-positive diplococci (GPDC)	☐	☐	☐	☐	☐
j.	Yeasts or other fungal elements	☐	☐	☐	☐	☐
k.	Leukocytes	☐	☐	☐	☐	☐

Bacterial Culture

6. Aerobic Plate: Was growth observed up to 96 hours? ☐ 1 - Yes ☐ 0 - No

7. Anerobic Plate: Was growth observed at 48 hours? ☐ 1 - Yes ☐ 0 - No

8. Was broth positive? ☐ 1 - Yes ☐ 0 - No

If the answer to Q6, Q7 AND Q8 are No, please skip to Q13.

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 28:
LAB RESULT: PLEURAL FLUID - LUNG ASPIRATE

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

9. Organism identification and quantification:

Organism Code	Found In 1 - Solid Media ☐ 2 - Broth ☐ 3 - Both ☐	Organism Quantity	Isolate ID (barcode label)	Organism Confirmation C – Confirmed U – Updated NC – Not Confirmed
a. Mixed skin flora	☐ ☐ ☐ ☐ 9-N/A			
b. Organism 1 ☐☐☐☐	☐ ☐ ☐	☐ 4: Scanty ☐ 1: 1+ ☐ 2: 2+ ☐ 3: 3+	Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C ☐ 2: U ☐ 3: NC
c. Organism 2 ☐☐☐☐	☐ ☐ ☐		Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C ☐ 2: U ☐ 3: NC
d. Organism 3 ☐☐☐☐	☐ ☐ ☐		Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C ☐ 2: U ☐ 3: NC
e. Organism 4 ☐☐☐☐	☐ ☐ ☐		Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C ☐ 2: U ☐ 3: NC

SITE LOGO

CRF 28:
LAB RESULT: PLEURAL FLUID - LUNG ASPIRATE

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

10. Antibiotic Susceptibility Testing:

Note: **1: S = Susceptible; 2: I = Intermediate; 3: R = Resistant**

	Organism 1		Organism 2		Organism 3		Organism 4	
	☐☐☐☐		☐☐☐☐		☐☐☐☐		☐☐☐☐	
Antibiotic code:	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code:**
a. AMC (Amoxicillin / Clavulanic acid)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
b. AMP (Amplicillin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
c. CAZ (Ceftazidimine)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
d. CH (Chloramphenicol)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
e. CIP (Ciprofloxacin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
f. CN (Gentamicin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
g. CRO (Ceftriaxone)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
h. CTX (Cefotaxime)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
i. DA (Clindamycin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
j. ERY (Erythromycin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
k. FOX (Cefoxitin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
l. IPM (Imipenem)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
m. OX (Oxacillin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
n. P (Penicillin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐

SITE LOGO

PERCH Pneumonia Etiology Research for Child Health

CRF 28:
LAB RESULT: PLEURAL FLUID - LUNG ASPIRATE

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

	Organism 1	Organism 2	Organism 3	Organism 4
	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
o. SXT (Cotrimoxazole)	☐☐ ☐	☐☐ ☐	☐☐ ☐	☐☐ ☐
p. TET (Tetracycline)	☐☐ ☐	☐☐ ☐	☐☐ ☐	☐☐ ☐
q. VA (Vancomycin)	☐☐ ☐	☐☐ ☐	☐☐ ☐	☐☐ ☐
r. Other: _____ Code: ☐☐☐☐	☐☐ ☐	☐☐ ☐	☐☐ ☐	☐☐ ☐
s. Other: _____ Code: ☐☐☐☐	☐☐ ☐	☐☐ ☐	☐☐ ☐	☐☐ ☐
t. Other: _____ Code: ☐☐☐☐	☐☐ ☐	☐☐ ☐	☐☐ ☐	☐☐ ☐
u. Beta lactamase	☐ 1 - Positive 2 - Negative ☐	☐ 1 - Positive 2 - Negative ☐	☐ 1 - Positive 2 - Negative ☐	☐ 1 - Positive 2 - Negative ☐

11. MIC Etest® results for *S. pneumoniae* isolates that are resistant (R) or intermediate (I) to oxacillin disk diffusion testing.

MIC Etest® performed? ☐ 1 – Yes ☐ 0 – No ☐ 9 – N/A *(If No or N/A, skip to Question 12)*

a. Penicillin Etest® results: ☐ < ☐ > ☐☐.☐☐☐ *µg/mL*

b. Ceftriaxone ☐ or Cetotaxime ☐ (choose one) ☐ < ☐ > ☐☐.☐☐☐ *µg/mL*

c. Clindamycin Dtest® results ☐ 1- Positive ☐ 2 – Negative

SITE LOGO

PERCH Pneumonia Etiology Research for Child Health

CRF 28:
LAB RESULT: PLEURAL FLUID - LUNG ASPIRATE

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

12. Screening for Extended Spectrum β-Lactamase (ESBL) Production done?

☐ 1 – Yes ☐ 0 - No

a. If Yes, results of additional phenotypic testing:

☐ 1 - ESBL confirmed ☐ 2 - ESBL not confirmed

Chemistry – Pleural Fluid Only

13. Results:

	Variable:	Result:	
a.	Protein	☐☐.☐	g/dL
b.	Glucose	☐☐.☐	mmol/L
c.	Not Done	☐	

14. Technician's Staff Code: ☐☐☐☐

BinaxNOW Pneumococcal Antigen Testing – Pleural Fluid Only

15. Technician's Staff Code: ☐☐☐☐

16. Test result: ☐ 1 – Positive ☐ 2 – Negative ☐ 3 – Indeterminate ☐ 9 - Not done

17. MIC Etest® results for *S. aureus* isolates that are resistant (R) or intermediate (I) to cefoxitin disk diffusion testing.

MIC Etest® performed? ☐ 1 - Yes ☐ 0 – No ☐ 9 – N/A

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 28:
LAB RESULT: PLEURAL FLUID - LUNG ASPIRATE

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

a. Vancomycin Etest® results < ☐ > . *µg/mL*

b. Clindamycin Dtest® results ☐ 1- Positive ☐ 2 – Negative

18. Was *S. pneumoniae* isolated?

☐ 1 – YES ☐ 0 – NO

If Yes, what serotypes were identified:

a. ☐☐☐☐☐☐☐☐☐☐

b. ☐☐☐☐☐☐☐☐☐☐

c. ☐☐☐☐☐☐☐☐☐☐

d. ☐☐☐☐☐☐☐☐☐☐

19. Was *H. influenza* isolated?

☐1-YES ☐0-NO

If Yes, what serotype was identified:

a. ☐☐☐☐

Comments:_____

_____

Supervisor Staff Code: ☐☐☐☐

Supervisor Verification Date: ☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 29:
LAB RESULT: PCP STAINING / FLUORESCENCE RESULTS

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

Specimen type *(check one)*:
- ☐ 1 - Induced sputum
- ☐ 2 - Pleural fluid
- ☐ 3 - Lung aspirate
- ☐ 4 - ETT aspirate

1. Specimen ID *(Scan or affix barcode label)*: Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

2. Date / time test performed: ☐☐ ***DAY*** ☐☐☐ ***MONTH*** ☐☐☐☐ ***YEAR*** ☐☐☐☐ ***TIME (24 hour clock)***

3. Technician's Staff Code: ☐☐☐☐

4. Type of test *(check one)*:
- ☐ 1 - Immunofluorescence
- ☐ 2 - Toluidine blue staining

5. Test result *(check one)*:
- ☐ 1 - Positive
- ☐ 2 – Negative

If Positive, check one:
- ☐ 1+ (<10 cysts per field)
- ☐ 2+ (11-100 cysts per field)
- ☐ 3+ (101-1000 cysts per field)
- ☐ 4+ (>1000 cysts per field)

Comments: _____

_____

_____

Supervisor Signature: _____ ***STAFF CODE***: ☐☐☐☐

☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 30:
PARTICIPANT EVENT FORM

PARTICIPANT ID

Event number:

Indicate which best categorizes the study participant event:

1. Category *(check one)*:

☐	01 - Safety
☐	02 - Informed consent
☐	03 - Protocol implementation
☐	99 - Other, specify: _____ Code:

2. Description of event:

_____

_____

_____

_____

Code:

3. Corrective action taken: ☐ 9 - N/A

_____

_____

_____

_____

Code:

4. Event start date: Day Month Year

5. Event end date: Day Month Year

6. Date reported to local ERC, if required: Day Month Year ☐ 9 - N/A

Comments:

_____

_____

_____

Form Completed by: _____ **Staff Code:**

Supervisor Signature: _____ **Staff Code:**

Supervisor Verification Date: Day Month Year

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 30A:
SITE EVENT FORM

XX

SITE ID

Event number: ☐☐

1. Description of event:

_____

_____

_____

_____

Code: ☐☐☐☐

2. Data that may be affected:

_____

_____

_____

_____

Code: ☐☐☐☐

3. Corrective action taken: ☐ 9 – N/A

_____

_____

_____

_____

Code: ☐☐☐☐

4. Event start date: ☐☐ Day ☐☐☐ Month ☐☐☐☐ Year

5. Event end date: ☐☐ Day ☐☐☐ Month ☐☐☐☐ Year

6. Date reported to local ERC, if required: ☐☐ Day ☐☐☐ Month ☐☐☐☐ Year ☐ 9 - N/A

Comments:

_____

_____

_____

_____

Form Completed by: _____ **Staff Code:** ☐☐☐☐

Supervisor Signature: _____ **Staff Code:** ☐☐☐☐

Supervisor Verification Date: ☐☐ Day ☐☐☐ Month ☐☐☐☐ Year

SITE LOGO

CRF 31:
CASE PRE-SCREENING

SITE ID

Reporting Period: Month Year

To be completed once a month

1. If reporting period start and end dates are not the first and last day of the month, record them here:

9- NA

   a. Start date: Day Month Year

   b. End date: Day Month Year

PART A: Pre-screening

2. Total under-five admissions (all days, all hours):

8- UNK

   a. Provide a brief description of the source of the above data:

_____

_____

2i. Total under-five admissions that are admitted to the hospital:

8- UNK

   a. Provide a brief description of the source of the above data:

3. Total under-five admissions who met the clinical screening trigger:

8- UNK

   a. Provide a brief description of the source of the above data:

_____

_____

4. Total under-five admissions during hours of screening:

8- UNK 9- NA

   a. Provide a brief description of the source of the above data:

_____

_____

SITE LOGO

CRF 31:
CASE PRE-SCREENING

SITE ID | Reporting Period: Month | Year

5. Total under-five admissions during the hours of screening who met the clinical screening trigger:

8- UNK 9- NA

a. Provide a brief description of the source of the above data:

6. Number of all patient screened (all ages): *(check NA if all screened are entered in EDC)*

8- UNK 9- NA

7. Number of admitted patient screened (all ages): *(check NA if all screened are entered in EDC)*

8- UNK 9- NA

a. If applicable, please provide additional information to describe why Q3 or Q5, as applicable, does not equal Q7 (i.e. explain why some hospitalized age-eligible children who met the clinical screening trigger were not screened).

PART B – For sites that do not submit CRF 01 for INELIGIBLE or NON-ENROLLED subjects

8. Of Q7 (screened and admitted), how many were eligible? 8- UNK

a. Of Q7 (screened and admitted), for how many was eligibility unknown? 8- UNK

9. Of Q8 (screened and eligible), how many were not enrolled for each of the reasons below:

a. Refused consent 8- UNK

b. Died 8- UNK

c. Met quota 8- UNK

d. Other 8- UNK

Other, specify: _____ Code:

SITE LOGO

CRF 31:
CASE PRE-SCREENING

SITE ID

Reporting Period: Month Year

10. Of Q6 (all patients screened) who were ineligible, how many were excluded for each of the reasons below:

a. Not from catchment area		8- UNK
b. Not age-eligible		8- UNK
c. No cough or difficulty breathing		8- UNK
d. No signs of severe or very severe pneumonia		8- UNK
e. Not admitted to hospital		8- UNK
f. Hospitalized within the past 14 days		8- UNK
g. PERCH case within past 30 days		8- UNK
h. LCWI resolved after BD challenge (severe cases only)		8- UNK
i. Other		8- UNK

Other, specify: _____ Code:

Comments: _____

_____

_____

_____

_____

_____

Form Completed by: _____ **Staff Code:**

Supervisor Signature: _____ **Staff Code:**

Supervisor Verification Date: **Day** **Month** **Year**

SITE LOGO

CRF 31Ai:
EPI CONTROL PRE-SCREENING

SITE ID

Reporting period: Month Year

To be completed once a month

1. If reporting period start and end dates are not the first and last day of the month, record them here:
   a. Start date: Day Month Year 9- NA
   b. End date: Day Month Year

PART A: Pre-Screening

2. Number of households visited <u>with an age-eligible child</u> for screening: 8- UNK

3. Of Q2 above (i.e., households with an age-eligible child), record the number of controls that <u>were not screened</u> (i.e., Screening Form CRF 01A was not completed) because:
   a. Guardian could not be located: 8- UNK 9- N/A
   b. Child out of town: 8- UNK 9- N/A
   c. They declined to be screened for PERCH: 8- UNK 9- N/A
   d. They did not appear at the clinic/hospital for enrollment: 8- UNK 9- N/A
   e. Other : 8- UNK 9- N/A

   Other, specify: _____ Code:

PART B – for sites that do not submit CRF 01A for <u>INELIGIBLE or NON-ENROLLED</u> screened subjects

4. Record the number of children screened: 8- UNK 9- N/A

5. Of Q4 (screened), how many were <u>eligible</u> but did not have CRF 01A entered into EDC? 8- UNK 9- N/A

Of Q5, record how many were not enrolled for each of the reasons below:

   a. Refused consent: 8- UNK
   b. Met quota: 8- UNK
   c. Other: 8- UNK

SITE LOGO

CRF 31Ai:
EPI CONTROL PRE-SCREENING

SITE ID

Reporting period: Month Year

Other, specify: _____ Code:

6. Of Q4 (screened), how many were ineligible and did not have CRF 01A entered into EDC? 8- UNK 9- N/A

Of Q6, record how many were ineligible for each of the reasons below:

a. Not from catchment area: 8- UNK

b. Not age-eligible: 8- UNK

c. Hospitalized within the past 14 days: 8- UNK

d. PERCH case within past 30 days: 8- UNK

e. Too sick (requires hospitalization): 8- UNK

f. Other: 8- UNK

Other, specify: _____ Code:

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

Form Completed by: _____ **Staff Code:**

Supervisor Signature: _____ **Staff Code:**

Supervisor Verification Date: Day Month Year

SITE LOGO

CRF 31Aii:
DSS CONTROL PRE-SCREENING

PERCH Pneumonia Etiology Research for Child Health

SITE ID

Reporting period: Month Year

To be completed once a month

1. If reporting period start and end dates are not the first and last day of the month, record them here:
   a. Start date: Day Month Year 9- NA
   b. End date: Day Month Year

PART A: Pre-Screening

2. Number of controls approached or attempted to enroll in PERCH: 8- UNK 9- N/A
   a. Number of controls approached from birth registry (SA only) 8- UNK 9- N/A

3. Of Q2, record the number of controls that were not screened (i.e., Screening Form CRF 01A was not completed/entered into the EDC) because:
   a. Could not be located (moved or not found at home after repeated visits) 8- UNK 9- N/A
   b. Declined to be screened 8- UNK 9- N/A
   c. Did not appear at the clinic/hospital for enrollment 8- UNK 9- N/A
   d. Died 8- UNK 9- N/A
   e. Incorrect DSS records (e.g. wrong age or address) 8- UNK 9- N/A
   f. Withdrew from surveillance (Bangladesh only) 8- UNK 9- N/A
   g. Recently provided specimens for surveillance or other studies (Bangladesh only) 8- UNK 9- N/A
   h. Enrolled in another study that prevents PERCH enrollment 8- UNK 9- N/A
   i. Other: 8- UNK 9- N/A
   Other, specify: _____ Code:

PART B: For sites that do not submit CRF 01A for INELIGIBLE or NON-ENROLLED subjects

4. Record the number of children screened: 8- UNK 9- N/A

SITE LOGO

CRF 31Aii:
DSS CONTROL PRE-SCREENING

SITE ID

Reporting period: Month Year

5. Of Q4 (screened), how many were eligible but did not have CRF 01A entered into EDC? 8- UNK 9- N/A

Of Q5, record how many were not enrolled for each of the reasons below:

a. Refused consent 8- UNK

b. Met quota 8- UNK

c. Other 8- UNK

Other, specify: _____ Code:

6. Of Q4 (screened) how many were ineligible and did not have CRF 01A entered into EDC? 8- UNK 9- N/A

Of Q6, record how many were ineligible for each of the reasons below:

a. Not from catchment area 8- UNK

b. Not age-eligible 8- UNK

c. Hospitalized within the past 14 days 8- UNK

d. PERCH case within past 30 days 8- UNK

e. Too sick (requires hospitalization) 8- UNK

f. Other 8- UNK

Other, specify: _____ Code:

Comments: _____

_____

Form Completed by: _____ **Staff Code:**

Supervisor Signature: _____ **Staff Code:**

Supervisor Verification Date: Day Month Year

SITE LOGO

CRF 31B:
HIV+ CONTROL PRE-SCREENING

SITE ID

Reporting period: Month Year

To be completed once a month to describe HIV-Infected Control Recruitment

1. If reporting period start and end dates are not the first and last day of the month, record them here:
   a. Start date: Day Month Year 9- NA
   b. End date: Day Month Year

PART A: Pre-Screening

2. Number of potentially eligible (i.e., in target age group) HIV-infected controls that were identified for screening: 8- UNK
3. Of Q2, record the number of controls that were not screened (i.e., Screening Form CRF 01B was not completed/entered into the EDC) because:
   a. Declined to be screened: 8- UNK 9- N/A
   b. Guardian could not be located: 8- UNK 9- N/A
   c. Enrolled in another study that prevents PERCH enrollment: 8- UNK 9- N/A
   d. Enrolled as PERCH control within past 3 months: 8- UNK 9- N/A
   e. Other: 8- UNK 9- N/A

   Other, specify: _____ Code:

PART B: For sites that do not submit CRF 01B for INELIGIBLE or NON-ENROLLED screened subjects

4. Record the number of children screened: 8- UNK 9- N/A
5. Of Q4 (screened), how many were eligible but did not have CRF 01B entered into EDC? 8- UNK 9- N/A

Of Q5, record how many were not enrolled for each of the reasons below:

   a. Refused consent: 8- UNK
   b. Met quota: 8- UNK
   c. Other: 8- UNK

   Other, specify: _____ Code:

SITE LOGO

CRF 31B:
HIV+ CONTROL PRE-SCREENING

SITE ID

Reporting period: Month Year

6. Of Q4 (screened), how many were ineligible and did not have CRF 01B entered into EDC? 8- UNK 9- N/A

Of Q6, record how many were ineligible for each of the reasons below:

a. Not from catchment area: 8- UNK

b. Not age-eligible: 8- UNK

c. Hospitalized within the past 14 days: 8- UNK

d. PERCH case within past 30 days: 8- UNK

e. Too sick (requires hospitalization): 8- UNK

f. Enrolled as PERCH control within past 3 months: 8- UNK

g. Other: 8- UNK

Other, specify: _____ Code:

Comments:

_____

_____

_____

_____

Form Completed by: _____ **Staff Code:**

Supervisor Signature: _____ **Staff Code:**

Supervisor Verification Date: Day Month Year

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 32:
MICROBIOLOGY REPORT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

1. Date/time put up for culture: ☐☐ *DAY* ☐☐☐ *MONTH* ☐☐☐☐ *YEAR* ☐☐☐☐ *TIME (24 hour clock)*

2. Specimen ID (scan barcode label): Scan or affix barcode label: ☐☐☐☐☐☐ – ☐☐

3. Technician's Staff Code: ☐☐☐☐

NOT DONE:
Stop here and end form if no lung biopsy specimen was taken.
☐

Gram Stain

4. Description of any organism found by Gram stain: ☐ No organisms seen (NOS - *skip to Q5*) ☐ N/A (Gram stain not done - *skip to Q5*)

Check the appropriate quanitifcation box for Q4a-k below.

	Organism	Not Seen	Scanty	1+	2+	3+
a.	Gram-negative rods (GNR)	☐	☐	☐	☐	☐
b.	Gram-positive cocci in clusters (GPC clusters)	☐	☐	☐	☐	☐
c.	Gram-negative coccobacilli (GNCB)	☐	☐	☐	☐	☐
d.	Gram-positive cocci in chains (GPC chains)	☐	☐	☐	☐	☐
e.	Gram-negative diplococci (GNDC)	☐	☐	☐	☐	☐
f.	Gram-positive cocci single cells (GPC singles)	☐	☐	☐	☐	☐
g.	Gram-negative cocci (GNC)	☐	☐	☐	☐	☐
h.	Gram-positive rods (GPR)	☐	☐	☐	☐	☐
i.	Gram-positive diplococci (GPDC)	☐	☐	☐	☐	☐
j.	Yeasts or other fungal elements	☐	☐	☐	☐	☐
k.	Leukocytes	☐	☐	☐	☐	☐

Bacteria per representative HPF (×100 oil objective)

<1	=	Scanty
1-9	=	1+
10-99	=	2+
≥100	=	3+

Number of leucocytes per representative LPF (×10 objective)

0	=	nil
1-9	=	1+
10-24	=	2+
≥25	=	3+

SITE LOGO

CRF 32:
MICROBIOLOGY REPORT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

Bacterial Culture

5. Aerobic Plate: Was growth observed up to 96 hours? ☐ 0 - No ☐ 1 - Yes ☐ 9 - Not done

6. Anerobic Plate: Was growth observed at 48 hours? ☐ 0 - No ☐ 1 - Yes ☐ 9 - Not done

7. Was broth positive? ☐ 0 – No ☐ 1 - Yes ☐ 9 - Not done

If the answers to Q5, Q6 AND Q7 are No or Not done, please end form.

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 32:
MICROBIOLOGY REPORT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

8. Bacterial culture organism identification and quantification:

Organism Code	Found In	Organism Quantity	Isolate ID (barcode label)	Organism Confirmation
a. Mixed skin flora*	1 - Solid Media ☐ 2 - Broth ☐ 3 - Both ☐ 9 – Not seen ☐			
b. Organism 1 ☐☐☐☐	☐ 1 - Solid Media ☐ 2 - Broth ☐ 3 - Both	☐ 4 - Scanty ☐ 1 - 1+ ☐ 2 - 2+ ☐ 3 - 3+	Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C - Confirmed ☐ 2: U - Updated ☐ 3: NC - Not Confirmed
c. Organism 2 ☐☐☐☐	☐ 1 - Solid Media ☐ 2 - Broth ☐ 3 - Both	☐ 4 - Scanty ☐ 1 - 1+ ☐ 2 - 2+ ☐ 3 - 3+	Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C - Confirmed ☐ 2: U - Updated ☐ 3: NC - Not Confirmed
d. Organism 3 ☐☐☐☐	☐ 1 - Solid Media ☐ 2 - Broth ☐ 3 - Both	☐ 4 - Scanty ☐ 1 - 1+ ☐ 2 - 2+ ☐ 3 - 3+	Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C - Confirmed ☐ 2: U - Updated ☐ 3: NC - Not Confirmed
e. Organism 4 ☐☐☐☐	☐ 1 - Solid Media ☐ 2 - Broth ☐ 3 - Both	☐ 4 - Scanty ☐ 1 - 1+ ☐ 2 - 2+ ☐ 3 - 3+	Insert barcode number or label: ☐☐☐☐☐☐ – ☐☐	☐ 1: C - Confirmed ☐ 2: U - Updated ☐ 3: NC - Not Confirmed

**Includes S. epidermidis and many species of Corynebacteria, Propionibacteria, Micrococci and Mycobacteria. See SOP for complete list.*

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 32:
MICROBIOLOGY REPORT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

9. Bacterial culture organism antibiotic susceptibility testing: ☐ N/A (not done)

	Organism 1		Organism 2		Organism 3		Organism 4	
	☐☐☐☐		☐☐☐☐		☐☐☐☐		☐☐☐☐	
Antibiotic code:	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code*:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code*:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code*:**	**Zone of inhibition in mm** (xx)**:**	**S / I / R Code*:**
a. AMC (Amoxicillin / Clavulanic acid)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
b. AMP (Amplicillin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
c. CAZ (Ceftazidimine)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
d. CH (Chloramphenicol)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
e. CIP (Ciprofloxacin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
f. CN (Gentamicin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
g. CRO (Ceftriaxone)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
h. CTX (Cefotaxime)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
i. DA (Clindamycin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
j. ERY (Erythromycin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
k. FOX (Cefoxitin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
l. IPM (Imipenem)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐

***S / I / R code:**

1: S = Susceptible
2: I = Intermediate
3: R = Resistant

SITE LOGO

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Pneumonia Etiology Research for Child Health

CRF 32:
MICROBIOLOGY REPORT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

	Organism 1		Organism 2		Organism 3		Organism 4	
	☐☐☐☐		☐☐☐☐		☐☐☐☐		☐☐☐☐	
Antibiotic code:	**Zone of inhibition in mm (xx):**	**S / I / R Code*:**	**Zone of inhibition in mm (xx):**	**S / I / R Code*:**	**Zone of inhibition in mm (xx):**	**S / I / R Code*:**	**Zone of inhibition in mm (xx):**	**S / I / R Code*:**
m. OX (Oxacillin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
n. P (Penicillin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
o. SXT (Cotrimoxazole)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
p. TET (Tetracycline)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
q. VA (Vancomycin)	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
r. Other: _____ Code: ☐☐☐☐	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
s. Other: _____ Code: ☐☐☐☐	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
t. Other: _____ Code: ☐☐☐☐	☐☐	☐	☐☐	☐	☐☐	☐	☐☐	☐
u. Beta lactamase	☐ 1 - Positive ☐ 2 - Negative		☐ 1 - Positive ☐ 2 - Negative		☐ 1 - Positive ☐ 2 - Negative		☐ 1 - Positive ☐ 2 - Negative	

SITE LOGO

PERCH
Pneumonia Etiology Research for Child Health

CRF 32:
MICROBIOLOGY REPORT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

10. MIC Etest® results for *S. pneumoniae* isolates that are resistant (R) or intermediate (I) to oxacillin disk diffusion testing.

Was MIC Etest® performed? ☐ 1 – Yes ☐ 0 – No ☐ 9 – N/A (*If No or N/A, skip to Question 11)*

a. Penicillin Etest® results: ☐ > ☐☐.☐☐☐ *µg/mL*
☐ <

b. Ceftriaxone ☐ or Cefotaxime ☐ (choose one) ☐ < ☐☐.☐☐☐ *µg/mL*
☐ >

11. Screening for Extended Spectrum β-Lactamase (ESBL) Production done?

☐ 1 - Yes ☐ 0 - No

a. If Yes, results of additional phenotypic testing:

☐ 1 - ESBL confirmed ☐ 2 - ESBL not confirmed

SITE LOGO

CRF 32:
MICROBIOLOGY REPORT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

12. Was *S. pneumoniae* isolated?

☐ 1 – Yes ☐ 0 – No

If Yes, what serotypes were identified:

a. ☐☐☐☐☐☐☐☐☐☐

b. ☐☐☐☐☐☐☐☐☐☐

c. ☐☐☐☐☐☐☐☐☐☐

d. ☐☐☐☐☐☐☐☐☐☐

13. Was *H. influenzae* isolated?

☐ 1-Yes ☐ 0-No

If Yes, what serotype was identified:

a. ☐☐☐☐

Technician Reporting Final Results: ☐☐☐☐

Initial QC By: ☐☐☐☐

Supervisor Staff Code: ☐☐☐☐

Supervisor Verification Date: ☐☐ ***Day*** ☐☐☐ ***Month*** ☐☐☐☐ ***Year***

SITE LOGO

PERCH Pneumonia Etiology Research for Child Health

CRF 33:
HISTOLOGY RESULT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

1. Biopsy Information

Biopsy available?	Specimen ID (scan barcode label):	Specimen quality *(check one)*:	Does biopsy show lung tissue?
a. H11? 1 - Yes ☐ 0 - No ☐	Scan or affix barcode label: ☐☐☐☐☐☐ H 11	1 - Good quality ☐ 2 - Poor/small/disrupted ☐	1 - Yes ☐ 0 - No ☐
b. H12? 1 - Yes ☐ 0 - No ☐	Scan or affix barcode label: ☐☐☐☐☐☐ H 12	1 - Good quality ☐ 2 - Poor/small/disrupted ☐	1 - Yes ☐ 0 - No ☐
c. H13? 1 - Yes ☐ 0 - No ☐	Scan or affix barcode label: ☐☐☐☐☐☐ H 13	1 - Good quality ☐ 2 - Poor/small/disrupted ☐	1 - Yes ☐ 0 - No ☐
d. H14? 1 - Yes ☐ 0 - No ☐	Scan or affix barcode label: ☐☐☐☐☐☐ H 14	1 - Good quality ☐ 2 - Poor/small/disrupted ☐	1 - Yes ☐ 0 - No ☐
e. H15? 1 - Yes ☐ 0 - No ☐	Scan or affix barcode label: ☐☐☐☐☐☐ H 15	1 - Good quality ☐ 2 - Poor/small/disrupted ☐	1 - Yes ☐ 0 - No ☐

MICROSCOPY (GENERAL QUESTIONS FOR CASE)

9 - NOT DONE: Stop here and end form ☐

2. Appearances: Do biopsies show abnormal / pathological features?

☐ 1 – No pathological appearances – Normal lung

☐ 2 – Pathology identified

3. Special Stains performed on biopsies

☐ 1 – None (H&E only)

☐ 2 – Yes: Specify _____

_____

SITE LOGO

PERCH Pneumonia Etiology Research for Child Health

CRF 33:
HISTOLOGY RESULT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: ☐☐ DAY ☐☐☐ MONTH ☐☐☐☐ YEAR

4. Histological Findings

	Pathological Feature	Present or Not (tick box if present)
a.	Pulmonary Edema	☐
b.	Pyogenic pneumonia (neutrophilic consolidation)	☐
c.	Lymphocytic infiltation of alveolar walls	☐
d.	Tuberculosis	☐
e.	Granulomas	☐
f.	Viral inclusion bodies	☐
g.	Hyaline membrane formation	☐
h.	Specific pathogen identified	☐
	If identified,type/s of pathogen:	1.
	(e.g. Fungi / Pneumoncystits jiroveci / Viral inclusions/TB)	2.
		3.
i.	Other pathological features	
	If identified, type of feature	1.
		2.
	Special Stains Positive? **If positive state:**	☐
j.	Gram Stain	☐
	If positive : Gram positive organisms	☐
	Gram negative organisms	☐
k.	Silver Stain	☐
l.	ZN Stain	☐
m.	Other (specify: _____)	☐
		☐

SITE LOGO

CRF 33:
HISTOLOGY RESULT: POST-MORTEM LUNG BIOPSY

DATE FORM INITIATED: | | | DAY | | | MONTH | | | | YEAR

Written Histology Report: (Summary report of Case across all available biopsies)

5. Histology Report:

Please note: if a clinical report has been issued on this case, an anonymous copy of the report can also be appended here

6. Final diagnosis: _____

_____

_____

7. Signature of examining pathologist: _____ Staff Code: | | | |

8. Date: | | *Day* | | | *Month* | | | | *Year*

Comments: _____

_____

Technician's Staff Code: | | | |

Supervisor Staff Code: | | | |

Supervisor Verification Date: | | *Day* | | | *Month* | | | | *Year*