Neonatal and Young Infant HSV Infection 12 Month Follow up	APSU Office Use Only	
Australian Paediatric Surveillance Unit	Study ID #:	
If you have any questions about this form please contact the APSU (02) 9845 3005; SCHN-APSU@health.nsw.gov.au	Month/Year Report:	
Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. DK=Don't Know; NA = Not Applicable;	*Version 1.0_ 11.11.2016*	

REPORTING CLINICIAN'S DETAILS

1. APSU Dr Code/Name: ____ ____ ____ ____/_____

2. Date questionnaire completed: ____ ____ /____ ____/____ ____ ____ ____

PATIENT DETAILS

3. First 2 letters of first name: ____ ____

4. First 2 letters of surname: ____ ____

5. Date of Birth: ____ ____ /____ ____/____ ____ ____ ____

6. Sex: ☐ Male ☐ Female

7. Postcode of family: ____ ____ ____ ____

8. Month/Year of Initial Report: ____ ____/____ ____ ____ ____

FOLLOW UP

9. Is the child still alive? ☐ Yes ☐ No ☐ DK

10. ***If No:*** Date of death: ____ ____ /____ ____/____ ____ ____ ____

Cause of death: _____

11. ***If Yes,*** follow up (by yourself or others) since the primary HSV infection? ☐ Yes ☐ No

12. *If YES*: Age at last visit: ☐☐ months

13. Prophylactic antiviral prescribed? ☐ Yes ☐ No ☐ DK

If Yes, Drug: _____

Dose: _____ mg/kg/day

Route: _____

Duration: ☐☐ month(s)

Start Date (month/year): ____ ____/____ ____ ____ ____

OUTCOME (as assessed at last follow up):

14. Was neurological examination done? ☐ Yes ☐ No ☐ DK

If yes: ☐ Normal ☐ Abnormal

If Abnormal, please specify: _____

15. Seizures? ☐ Yes ☐ No ☐ DK

16. Developmental assessment Done? ☐ Yes ☐ No ☐ DK

If yes: ☐ Normal ☐ Abnormal

If Abnormal: ☐ Mild ☐ Moderate ☐ Severe

Specify nature of impairment: _____

17. Eye examination done? ☐ Yes ☐ No ☐ DK

If yes: ☐ Normal ☐ Abnormal

18. Other physical/social sequelae of the neonatal HSV infection? ☐ Yes ☐ No ☐ DK

If yes, please specify: _____

RECURRENCES

19. Recurrence of HSV disease? ☐ Yes ☐ No ☐ DK

If Yes, how many recurrences? _____

If No, no further information is required. Thank you.

20. ***If Yes,*** Site: ☐ Cutaneous ☐ Eye ☐ CNS

☐ Other, specify site: _____.

Management

Please provide details of management for each of the recurrences. If there was more than 1 recurrence please print another case report form and complete the patient details and details of the additional recurrence.

21. Hospital admission? ☐ Yes ☐ No ☐ DK

Name of Hospital: _____

22. Antiviral therapy? ☐ Yes ☐ No ☐ DK

Drug used: _____

Route: _____

Dose: _____ mg/kg/day

23. Lumbar puncture performed? ☐ Yes ☐ No ☐ DK

If Yes, Date: ____ ____ /____ ____ /____ ____ ____ ____

24. ***If Yes*****:** CSF HSV PCR: ☐ Positive ☐ Negative ☐ Not done

CSF white cell count: ☐☐☐☐ /mm^3

CSF red cell count: ☐☐☐☐ /mm^3

25. HSV lesion/swab culture or PCR: ☐ Yes ☐ No ☐ DK

Site: _____

Result: _____

Thank you for your assistance with this research project

Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au
or by mail to: Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145
or via Fax: (02) 9845 3082
- even if all the sections have not been completed.

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Faculty of Medicine and Health, The University of Sydney.
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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines