

Congenital Rubella Australian Paediatric Surveillance Unit If you have any questions about this form, please contact the APSU (02) 9845 3005 or email SCHN-APSU@health.nsw.gov.au	APSU Office Use Only
	Study ID #:
	Month/Year Report:
<i>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</i>	
	Version

REPORTING CLINICIAN

1. APSU Dr Code/Name / _____

2. Month/Year of Report _____ / _____

3. Date questionnaire completed / /

PATIENT

4. First 2 letters of first name:

5. First 2 letters of surname:

6. Date of Birth: / /

7. Sex: M F

8. Post code:

9. Date of diagnosis: / / (DD/MM/YY)

10. Country of Birth: Australia Other, specify: _____ DK

11. Mother's country of birth: Australia Other, specify: _____ DK

12. Father's country of birth: Australia Other, specify: _____ DK

13. Is the child of Aboriginal or Torres Strait Islander origin?
 Yes No DK

If this patient is primarily cared for by another physician whom you believe will report the case, please write the other physician's name and complete questionnaire details above this line and return.

If no other report is received for this child we will contact you for further information.

Please keep the patient's name and other details on your APSU file.

The primary clinician caring for this child is: **Name**

Hospital:

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

PATIENT'S CLINICAL DETAILS

14. Birth weight: _____ grams

15. Gestational age at birth: _____ weeks

16. a. Were there neonatal signs? Yes No DK
 b. **If yes**, please specify: _____

17. a. Congenital rubella defects present? Yes No DK
 b. **If yes**, please specify: _____

18. Failure to thrive/developmental delay? Yes No DK

19. a. Deafness? Unilateral Bilateral No DK
 b. Severity of hearing impairment: Mild Moderate Severe NA

20. a. Congenital heart disease? Yes No DK
 b. *If yes*, please specify: _____
21. Cataracts? Unilateral Bilateral No DK
22. Retinopathy? Yes No DK
23. Developmental delay? Mild Moderate Severe No DK NA
24. Please specify any other defect (s)? (e.g. Congenital glaucoma, Microcephaly, Purpura, Hepatosplenomegaly, Meningoencephalitis, Radioluscent bone disease): _____

25. Laboratory confirmation of congenital rubella? Serology IgM + ve Virus isolated DK Not done
26. a. Is the patient still living? Yes No DK
 b. If not, what was the date of death? / / (DD/MM/YY)

FAMILY AND PREGNANCY

27. a. If you do not know the answers to the following questions, is there another medical practitioner from whom we could obtain this information? Yes No DK
 b. Could you please provide the name and address of patient's obstetrician or general practitioner to whom we could send a questionnaire? _____
28. Mother's age when this child was born (in years) years
29. Affected child's rank in family
 (e.g. 1 of 3, 2 of 4, 1 of 1) _____ of _____
30. a. Did mother have rubella contact in pregnancy? Yes No DK
 b. *If yes*, state stage of pregnancy in weeks from LMP: weeks
 c. Was this contact living in the same household? Yes No DK
 d. Did mother received any post-exposure prophylaxis with NHIG? Yes No DK
31. a. Did mother have a rubella-like illness WITH RASH in pregnancy? Yes No DK
 b. *If yes*, state stage of pregnancy in weeks from LMP: weeks
32. a. Did mother have a rubella-like illness WITHOUT RASH in pregnancy? Yes No DK
 b. If yes, state stage of pregnancy in weeks from LMP: weeks
33. a. Has there been serological confirmation of rubella in pregnancy? Yes No DK
 b. Give dates and test results if possible _____
34. What is the mother's ethnic background? _____ DK
35. What is the father's ethnic background? _____ DK

MOTHER'S RUBELLA VACCINATION HISTORY

36. Had mother been vaccinated for rubella? Yes No DK
37. Was mother vaccinated in the schoolgirl program? Yes No DK
38. Had mother received MORE than one vaccination for rubella prior to this pregnancy? Yes No DK
39. Had mother had a positive rubella antibody titre documented prior to this pregnancy? Yes No DK
40. If mother NOT vaccinated, do you know why she was not vaccinated? (e.g. thought she had had rubella, was not living in Australia, asthma etc) _____

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**

*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.
The APSU is funded by the Australian Government Department of Health.
This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines*