Congenital Cytomegalovirus (CMV) Infection Questionnaire
Australian Paediatric Surveillance Unit

If you wish to discuss this questionnaire please contact Study Co-ordinator, Beverley Hall
Prince of Wales Hospital, High Street, Randwick NSW 2031
Tuesday and Thursday Tel: 02 9382 9243 Fax: 02 9382 8533 APSU FAX: 02 9845 3082 (OTHER STATES)

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: ☐☐ month/ ☐☐ year
10. Country of Birth: Australia ☐ Other ☐ specify_____ ☐ Don't know
11. Mother's country of birth Australia ☐ Other ☐ specify_____ ☐ Don't know
12. Father's country of birth Australia ☐ Other ☐ specify_____ ☐ Don't know
13. Is the child of Aboriginal or Torres Strait Islander origin ☐ Yes ☐ No ☐ Don't know

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 information requested in the remainder of the questionnaire.

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

PATIENT

14. Age of child when CMV first suspected:_____
14.a Gestation of child at birth: _____
15. Were there any other abnormalities, congenital infections or other significant conditions present?
Yes ☐ No ☐ DK ☐ **If yes, please specify**: _____
16. Child's clinical results:

a. IgG serology positive ☐ negative ☐ DK ☐ Not done ☐ Date of test ☐☐ /☐☐/☐☐
b. IgM serology positive ☐ negative ☐ DK ☐ Not done ☐ Date of test ☐☐ /☐☐/☐☐
c. Viral culture positive ☐ negative ☐ DK ☐ Not done ☐ Date of test ☐☐ /☐☐/☐☐
d. Urine PCR positive ☐ negative ☐ DK ☐ Not done ☐ Date of test ☐☐ /☐☐/☐☐
e. Blood PCR positive ☐ negative ☐ DK ☐ Not done ☐ Date of test ☐☐ /☐☐/☐☐
f. Newborn Screen(Guthrie Card) positive ☐ negative ☐ DK ☐ Not done ☐ Date of test ☐☐ /☐☐/☐☐
g. Cord Blood positive ☐ negative ☐ DK ☐ Not done ☐ Date of test ☐☐ /☐☐/☐☐

MOTHER OF CHILD

17. Gravida _____ Para_____ Date of Birth or Age ☐☐ /☐☐/☐☐ _____
18. Mother's serology:

a. IgG serology positive ☐ negative ☐ DK ☐ Not done ☐
b. IgM serology positive ☐ negative ☐ DK ☐ Not done ☐
c. Viral culture positive ☐ negative ☐ DK ☐ Not done ☐
d. Urine PCR positive ☐ negative ☐ DK ☐ Not done ☐
e. Blood PCR positive ☐ negative ☐ DK ☐ Not done ☐
f. Mother's serology done? Prior to pregnancy ☐ During pregnancy ☐ After delivery ☐ DK ☐ Not done ☐

19. Did the mother suffer illness during pregnancy? ☐ Yes ☐ No ☐ DK **If yes, please complete a - d below:**

a. please specify the nature of the illness _____
b. did she have fever? ☐ Yes ☐ No ☐ DK **If yes, how long did it last?** _____days
c. did she have rash? ☐ Yes ☐ No ☐ DK
d. did she have flu-like symptoms? ☐ Yes ☐ No ☐ DK

CLINICAL CONDITIONS PRESENT IN THE CHILD		**If yes, age of occurrence or diagnosis**
20. Small for gestational age	☐ Yes ☐ No ☐ DK	
21. Developmental delay	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
22. Encephalitis	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
23. Microcephaly	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
24. Intracranial calcification	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
25. Seizures	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
26. Deafness	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
27. Cataracts	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
28. Chorioretinitis	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
29. Microphthalmia	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
30. Splenomegaly	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
31. Anaemia	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
32. Thrombocytopaenia	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
33. Petechiae, purpura	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
34. Hepatitis	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
35. Hepatomegaly	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
36. Jaundice	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
37. Pneumonitis	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
38. Myocarditis	☐ Yes ☐ No ☐ DK	_____ (wk or mth?)
39. Undescended testes	☐ Yes ☐ No ☐ DK ☐ NA	_____ (wk or mth?)

TREATMENT AND OUTCOME

40. Was antiviral treatment given? ☐ Yes ☐ No ☐ DK

41. **If antiviral treatment given, what antiviral was used?** _____

Date commenced: ☐☐ / ☐☐ / ☐☐ ☐ NA

42. Has the child died? ☐ Yes ☐ No ☐ DK **If yes, date of death**: ☐☐ / ☐☐ / ☐☐

Thank you for your assistance with this study.

PLEASE RETURN THIS FORM EVEN IF ALL THE SECTIONS HAVE NOT BEEN COMPLETED

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