Newborn and Infant Herpes Simplex Virus Infection Questionnaire (V2- 2012)
Australian Paediatric Surveillance Unit

Please contact Prof CHERYL JONES on (02) 9845 3382 cheryl.jones@health.nsw.gov.au or APSU (02) 9845 3005 apsu@health.nsw.gov.au if you have any questions about this form. Please keep a record of the child's unit number in your APSU folder.

Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. DK= Don't Know

REPORTING CLINICIAN DETAILS

1. APSU Dr Code/Name ☐☐☐☐ /…… 2. Month/Year of Report …..… /……

3. Date questionnaire completed ☐☐ /☐☐/☐☐ 4. Date patient first seen by you: ☐☐/☐☐/☐☐

PATIENT

5. First 2 letters of first name ☐☐ 6. First 2 letters of surname ☐☐ 7. Post code ☐☐☐☐

8. Sex: ☐ M ☐ F 9. Date of Birth: ☐☐/☐☐/☐☐

10. Multiple Birth? ☐ Yes ☐ No If yes, specify birth order (e.g. Twin 2) …….

MATERNAL

11. Mother's age in years ☐☐ 12. Mother's country of birth ☐ Australia ☐ Other: .....

If mother was born in Australia is she an ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and TSI

13. Number of previous pregnancies: …….. 14. Number of previous deliveries: ……

If this patient is primarily cared for by another physician who you believe will report the case, and could provide additional details, please write the other physician's name in the space below and then complete the details above this line and return to APSU. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

The primary clinician caring for this child is: ***Name:*** ***Practice or Hospital:***

Birth details

15. Birth weight (grams) ☐☐☐☐ 16. Gestational age at birth ☐☐ completed weeks

17. Delivery: ☐ Vaginal - no instruments ☐ Instrumental vaginal ☐ Caesarean

18. Time between membrane rupture and delivery ☐☐ hours ☐ DK

19. Was a scalp monitor applied? ☐ Yes ☐ No ☐ DK

20. Age baby first saw a doctor with manifestations of possible HSV infection ? ☐☐ months or ☐☐ days

Clinical Manifestations in the Infant

21. Please indicate where (in which system) clinical signs were noted and age (in days) when these first manifested

			Age of onset (months or days)	
(a)Skin, Eyes or Mouth	☐ Yes	☐ No	☐☐ months	☐☐days
(b)Central nervous system (e.g. seizures, lethargy	☐ Yes	☐ No	☐☐ months	☐☐days
(c)Respiratory (e.g. apnoea, pneumonitis)	☐ Yes	☐ No	☐☐ months	☐☐days
(d)Hepatic (i.e. Elevated liver function tests, jaundice)	☐ Yes	☐ No	☐☐ months	☐☐days
(e)Bleeding or DIC	☐ Yes	☐ No	☐☐ months	☐☐days
(f)Cardiac (e.g. hypotension, poor perfusion)	☐ Yes	☐ No	☐☐ months	☐☐days
(g)Fever	☐ Yes	☐ No	☐☐ months	☐☐days
(h)Other (specify system):……	☐ Yes	☐ No	☐☐ months	☐☐days

Investigations on Infant

If these specimens were sent please complete the results (or write "ND" for Not Done or DK for Don't know)

How was HSV infection in this baby confirmed?

22. HSV culture positive? ☐ Yes ☐ No ☐ Not done ☐ DK Site(s) .....

23. HSV PCR positive? ☐ Yes ☐ No ☐ Not done ☐ DK Site(s) .....

24. HSV Immunofluorescence positive? ☐ Yes ☐ No ☐ Not done ☐ DK Site(s) .....

25. HSV typing (on any sample) ☐ HSV 1 ☐ HSV 2 ☐ Not done ☐ DK

26. HSV PCR on Plasma infant ☐ Positive ☐ Negative Age at test ☐☐ days

27. HSV PCR on Amniocentesis? ☐ Positive ☐ Negative Gestation ☐☐ weeks

CSF Examination Results?

28. Was a lumbar puncture performed at diagnosis? ☐ Yes ☐ No ☐ DK If YES, Date ……/……/.....

29. If YES, Number of white cells/mm^3 ☐☐☐☐☐ Number of red cells/mm^3 ☐☐☐☐☐

CSF HSV PCR ☐ Positive ☐ Negative ☐ Not Done

The Australian Paediatric Surveillance Unit is a unit of the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and is funded by the NHMRC (Enabling Grant No. 402784); the Australian Government Department of Health and Ageing; and Sydney Medical School, University of Sydney. This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.

Revised, July 6 2011

Treatment, follow up investigations, and prophylaxis of the Infant

30. Was the baby treated for HSV infection? ☐ Yes ☐ No ☐ DK If YES please provide details

DRUG Used	Age when started		Dose mg/ kg/ per/ day	Route	Duration (days)
	months	days			

31. Were antiviral drugs given at prophylaxis to prevent recurrence after treatment course completed? ☐ Yes ☐ No ☐ DK
If YES please provide details:

DRUG Used	Age when started		Dose mg/ kg/ per/ day	Route	Duration (days)
	months	days			

32. Was a lumbar puncture performed at the end of antiviral therapy? ☐ Yes ☐ No ☐ DK If YES, Date ……/……/.....

33. If YES, Number of CSF white cells/mm^3 ☐☐☐ Number of CSF red cells/mm^3 ☐☐☐
CSF HSV PCR result ☐ Positive ☐ Negative ☐ Not Done

34. Convalescent CSF HSV IgG and IgM: (specify result) ..... Date ……/……/.....

Cerebral imaging on Infant

35. CNS imaging performed? ☐ Yes ☐ No

36. If YES, CNS Imaging modality ☐ Ultrasound ☐ CT scan ☐ MRI scan ☐ Other (Specify)

37. CNS Imaging result ☐ Normal ☐ Abnormal Date of scan ☐☐/☐☐/☐☐ ☐ Not Done

Please specify result .....

Outcome at this presentation

38. Infant: ☐ survived ☐ died 39. If died, Date of death ☐☐/☐☐/☐☐

40. If survived, were there obvious sequelae at discharge: ☐ Yes ☐ No ☐ DK
If yes, please specify .....

Source of infection

Genital Herpes	Mother	Father	Other maternal sexual partner
41. No known genital herpes at any time	☐	☐	☐
42. Genital herpes before (& during) this pregnancy	☐	☐	☐
43. Genital herpes during this pregnancy for first time	☐	☐	☐
44. Genital herpes first time diagnosed after delivery	☐	☐	☐
45. Other	☐	☐	☐

Non-Genital Herpes	Mother	Father	*Other (please specify)
46. Past history of non genital herpes (oral or whitlow)	☐	☐	☐ .....
47. Oral herpes at or soon after delivery	☐	☐	☐ .....
48. Herpetic whitlow at or soon after delivery	☐	☐	☐ .....

other = contact other than parent eg; Hospital staff /Sibling/Relative.

49. If mother had herpes before/during this pregnancy, was antiviral therapy given during pregnancy? ☐ Yes ☐ No ☐ DK

50. If YES, please provide details

DRUG Used	Dose mg/ kg/ per/ day	Route	Duration (days)

Maternal Investigations:

51. Was the mother's HSV type specific antibody status tested? Yes ☐ No ☐

If YES a) HSV-1 IgM Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/.....
b) HSV-1 IgG Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/.....
c) HSV-2 IgM Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/.....
d) HSV-2 IgG Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/.....

Thank you for your help with this research. Please return this questionnaire by Fax (02) 9845 3082, email (apsu@chw.edu.au) or by reply-paid envelope to the APSU, Kid's Research Institute, The Children's Hospital at Westmead, Locked Bag 4001, Westmead, NSW 2145.

A follow-up questionnaire will be sent 12 months after the initial presentation

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