

Neonatal Varicella Infection Questionnaire
Australian Paediatric Surveillance Unit

Please ring Prof Robert Booy on 02 98451415 if you wish to discuss this questionnaire.

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. Birth weightgrams (if Known)
11. Gestational age at birthweeks (if Known)
12. Country of Birth Australia Other specify _____ DK
13. Mother's country of birth Australia Other specify _____ DK
14. Father's country of birth Australia Other specify _____ DK
15. 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

Section A: Diagnosis of neonatal varicella infection

16. How was varicella infection diagnosed in the infant? Clinical Laboratory Both
17. If laboratory, which tests were +ve? (tick all that apply) Culture PCR EM IF Serology
18. a. Give age when illness commenced
- b. Approximate duration of illnessdays
- c. Did the infant spend time in hospital due to varicella? Yes No DK
- If yes, number of days in hospital
- e. Was the infant admitted to ICU/HDU? Yes No DK If yes, number of days in ICU/HDU.....

Section B: Clinical Features that can be attributed to varicella

19. Did the child have any of the following: (tick all that apply)

- a. Skin lesions consistent with varicella Yes No DK
- b. Bacteraemia / septic shock Yes No DK
- c. Toxic shock / toxin mediated disease Yes No DK
- d. Necrotising fasciitis Yes No DK
- e. Encephalitis Yes No DK
- f. Purpura fulminans Yes No DK
- g. Disseminated coagulopathy Yes No DK
- h. X-Ray evidence of pneumonia Yes No DK
- i. Fulminant varicella (multi-organ involvement) Yes No DK
- j. Reye's Syndrome Yes No DK
- k. Hepatitis Yes No DK
- l. Other

20. If there is/was concurrent or secondary infection state site of infection, sample type and organism:

Site	Sample Type	Organism
<i>e.g. brain</i>	<i>e.g. CSF</i>	<i>e.g. Staphylococcus Aureus</i>
.....
.....
.....

Section C. Underlying medical conditions

21. Is the patient immunocompromised? Yes No DK
 If yes, specify.....
22. Has the patient any other significant underlying illness? Yes No DK
 If yes specify.....

Section D. Management

23. Did the child receive any specific treatment? Yes No DK **If No/DK, go to section E**
24. Antiviral agent Yes No DK
 Aciclovir Date of first dose..... Dose:..... Date ceased:.....
 Famciclovir Date of first dose..... Dose:..... Date ceased:.....
 Valaciclovir Date of first dose..... Dose:..... Date ceased:.....
25. Zoster Immune Globulin Yes No DK Date:.....
26. Other treatments? Yes No DK
 If yes, describe:.....

Section E. Outcome

27. What is the patient's current status? Still hospitalised **GO TO Q28**
 Dead **GO TO Q27a** Discharged alive **GO TO Q27b**
- (a) If the child died, was varicella, or its complications, a cause of death? Yes No DK
 (b) If the child was discharged, were there any ongoing problems on discharge? Yes No DK
 Specify.....

Section F. About Exposure to Varicella of Mother and Infant

28. Was there a history of varicella exposure for the infant? Intrauterine Postnatal No DK
If intrauterine, go to question 29. If postnatal, go to Question 34.
If No/DK, questionnaire is finished.
29. During pregnancy, did the mother have contact with someone infected with varicella? Yes No DK
 If Yes, gestation in weeks from LMPweeks
30. Was maternal varicella infection confirmed by laboratory testing? Yes No DK
 If Yes, which laboratory tests were +ve? Culture PCR EM IF Serology
31. Did the mother have a varicella-like illness in pregnancy? Yes No DK
 (a) If yes, stage of pregnancy in weeks from LMPweeks
 (b) What treatment was provided to the mother for the varicella-like illness?
 Zoster immune globulin Aciclovir Famciclovir Valaciclovir None DK
 Other (specify)
32. Who was the contact? (eg. friend, relative).....
 If Contact was a child please give age:..... or DK
33. Was this contact living in the same household as the mother or affected infant? Yes No DK
34. Was the contact vaccinated against varicella? Yes No DK

**Please return this questionnaire in the addressed reply-paid envelope to
 Dr Yvonne Zurynski, Australian Paediatric Surveillance Unit, Locked Bag 4001, Westmead, 2145, NSW**