Stroke in Australian Children Under 2 Years of Age Australian Paediatric Surveillance Unit Please contact the APSU (02) 9845 3005; SCHN-APSU@health.nsw.gov.au If you have any questions about this form	*APSU Office Use Only*	
	Study ID #:	
	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: 08.11.2016*	

REPORTING CLINICIAN'S DETAILS:

1. APSU Dr Code/Name: ☐☐☐☐/_____ **2**. Date questionnaire completed: __ __ / __ __ / __ __ __ __

PATIENT DETAILS (THIS CHILD)

3. First 2 letters of first name: ___ ___ **4.** First 2 letters of surname: ___ ___ **5.** Postcode of family: ___ ___ ___ ___

6. Racial background *(select all that apply)*: ☐ Aboriginal ☐ Caucasian ☐ Pacific Islander ☐ Torres Strait Islander ☐ African

☐ Asian ☐ DK ☐ Other *(specify):* _____ **7.** Date of Birth: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)

8. Sex: ☐ Male ☐ Female ☐ Indeterminate **9.** Did you make the diagnosis? ☐ Yes (***please go to Q10***) ☐ No – if this patient is primarily cared for by another physician who you believe could provide additional details, please write their name below and return this form to the APSU. If no other reports are received for this child we will contact you for further information.

Physician's Name: _____ Clinic/Hospital: _____

DIAGNOSIS OF STROKE FOR THIS CHILD

10. Date of Diagnosis of Stroke: __ /__ /__ __ __ __ (dd/mm/yyyy)

11. Type of Stroke event (a patient can have multiple types of stroke event): (*Select all that apply*)

☐ Arterial Ischemic Stroke (AIS) ☐ Periventricular Venous Infarction (PVI) ☐ Cerebral Sinovenous Thrombosis (CSVT)

☐ Haemorrhagic Stroke (NHS) ☐ Other; Specify:_____

12. Other diagnoses: ☐ Generalised Sepsis ☐ Meningitis ☐ Other infection; Specify:_____

☐ Congenital heart disease (specify CHD type):_____ _____

(specify interventions): _____

☐ Other congenital anomalies (specify):_____

☐ Other Diagnoses (specify)_____

HISTORY DURING PREVIOUS PREGNANCIES

13. (a) Miscarriage: ☐ Yes ☐ No ☐ DK ***If yes,*** Specify number_____

(b) Stillbirth: ☐ Yes ☐ No ☐ DK ***If yes,*** Specify number_____ Specify gestation for each _____

(c) Neonatal death: ☐ Yes ☐ No ☐ DK ***If yes,*** Specify number_____ Specify gestation for each _____

PREGNANCY HISTORY (THIS PREGNANCY)

14. Maternal age *(completed yrs)*:_____ (yrs) **15.** Consanguinity: ☐ Yes ☐ No ☐ DK **16.** Parity: Gravida____ Parity___ ☐ DK

17. Was conception: ☐ Natural ☐ IVF ☐ Other *(specify)*: _____ ☐ DK

18. (a) Complications during this pregnancy: ☐ Yes ☐ No ☐ DK ***If Yes,*** ☐ pre-eclampsia ☐ IUGR ☐ Placental blood flow abnormality ☐ Other *(specify)*: _____

(b) Were there any abnormal antenatal US reports: ☐ Yes ☐ No ☐ DK ***If yes,*** Specify: _____

(c) Was there evidence of meconium stained liquor: ☐ Yes ☐ No ☐ DK

(d) Was there evidence of Chorioamnionitis?☐ Yes ☐ No ☐ DK ***If yes,*** ☐ Clinically suspected ☐ Pathologically proven ☐ Both ☐ DK

(e) Did the mother have any positive microbial cultures during pregnancy? ☐ Yes ☐ No ☐ DK,

If yes, GBS in High Vaginal Swab?: ☐ Yes ☐ No ☐ DK

☐ Urine culture (Specify pathogen(s): _____---_____;

☐ Other +ve cultures, Specify pathogen(s): _____

(f) During pregnancy did the mother take: ☐ warfarin ☐ phenytoin ☐ barbiturates

☐ Other medications(specify): _____ ☐ No ☐ DK

(g) During pregnancy did the mother: Smoke ☐ Yes ☐ No ☐ DK; Drink alcohol ☐ Yes ☐ No ☐ DK;

Take Illicit drugs ☐ Yes ☐ No ☐ DK ***If yes,*** specify: _____

19. Is there a family history of childhood stroke: (i) In parents ☐Yes ☐No ☐DK (ii) In siblings ☐Yes ☐No ☐DK

(iii) In first degree relatives ☐Yes ☐No ***If yes,*** specify first degree relative: _____

BIRTH INFORMATION AND INTERVENTIONS (THIS CHILD)

20. Gestational age:_____ (completed wks) ☐DK

21. i) Birth Weight: _____ (g) ☐ DK **ii)** Birth Length: _____ (cm) ☐ DK **iii)** Birth Head Circumference: _____ (cm) ☐ DK

22. Vitamin K given?: ☐ Yes ☐ No ☐ DK ***If yes,*** ☐ Oral ☐ IM, ***If Oral*** were all 3 doses given? ☐ Yes ☐ No ☐ DK

23. Mode of delivery: ☐ Normal Vaginal Delivery ☐ Vacuum ☐ Forceps ☐ Elective Cesarean Section

☐ Emergency Cesarean Section ☐ Vaginal Breech Delivery ☐ DK

24. Was this a difficult delivery: ☐ Yes ☐ No ☐ DK ***If yes,*** ☐ Shoulder dystocia ☐ Multiple vacuum attempts ☐ Failed vacuum

☐ Other Please specify:_____

25. Plurality: ☐ Singleton ☐ Twin 1 ☐ Twin 2 ☐ Triplet 1 ☐ Triplet 2 ☐ Triplet 3 ☐ Other ☐ DK

If twin or triplet, type (select one): ☐ MCMA ☐ MCDA ☐ DCDA ☐ MCTA ☐ TCTA ☐ DK ☐ Other: _____

26. Death of Co-twin / Co-triplet: ☐ Yes ☐ No ☐ DK **If yes,** ☐ Death before birth ☐ after birth Cause of death:_____ ☐DK

27. Apgar Scores: 1min ___ ☐ DK; 5min ___ ☐ DK; 10min ____ ☐ DK

28. Cord blood gas**?** ☐ Yes ☐ No ☐ DK ***If yes,*** ☐ Arterial Cord / ☐ Venous cord

pH _____ /_____ pCO2 _____ /_____ Base Excess _____ /_____ Lactate _____ /_____

29. Resuscitation required at birth? ☐ Yes ☐ No ☐ DK

If yes, ☐ Suction ☐ Oxygen ☐ IPPV ☐ CPAP ☐ Intubation ☐ Chest compression ☐ Adrenaline ☐ Fluid Bolus

30. Did the child need vascular catheterisation? ☐ Yes ☐ No ☐ DK ***If yes,*** ☐ Umbilical artery ☐ Umbilical vein ☐ Femoral artery

☐ Femoral vein ☐ Cardiac catheterisation ☐ Other specify:_____

CLINICAL PRESENTATION OF STROKE (THIS CHILD)

31. Date of clinical onset of symptoms: __ /__ /__ __ __ __ (dd/mm/yyyy)

32. Clinical Presentation *(please tick all that apply)*: ☐ Poor feeding ☐ Tachypnoea ☐ Apnoea ☐ Cyanosis ☐ Hypoglycaemia

☐ Abnormal tone and reflexes ☐ Lethargy ☐ Abnormal level of consciousness ☐ DK

☐ Seizures: ☐ Yes ☐ No ☐ DK ***If yes,*** Type of Seizures - ☐ Focal right ☐ Focal left ☐ Multifocal ☐ Generalised ☐ Subtle

☐ Hemiparesis: ☐ Yes ☐ No ☐ DK ***If yes,*** Specify: ☐ Right ☐ Left ☐ Bilateral ☐ None ☐ DK

☐ Other; specify: _____

INVESTIGATIONS FOR STROKE (THIS CHILD)

33. Brain Imaging: (i) Was MRI done? ☐ Yes ☐ No ☐ DK ***If yes,*** Date __ /__ / __ __ __ _ (dd/mm/yyyy)

(ii) Was CT done? ☐ Yes ☐ No ☐ DK ***If yes,*** Date __ /__ /__ __ __ __ (dd/mm/yyyy)

(iii) Was Ultrasound done? ☐ Yes ☐ No ☐ DK ***If yes,*** Date __ /__ /__ __ __ __ (dd/mm/yyyy)

34. (i) EEG done? ☐ Yes ☐ No ☐ DK ***If yes***: Date __ /__ /__ __ __ __ (dd/mm/yyyy)

(ii) Full blood count: ☐ Yes ☐ No ☐ DK ***If yes,*** any abnormalities? _____

(iii) Coagulation profile: ☐ Yes ☐ No ☐ DK ***If yes,*** any abnormalities? _____

(iv) Positive culture: ☐ Yes ☐ No ☐ DK ***If yes,*** ☐ Blood ☐ Urine ☐ CSF Specify: _____

(v) Echocardiography: ☐ Yes ☐ No ☐ DK ***If yes,*** findings? _____

(vi) Newborn Screening: ☐ Yes ☐ No ☐ DK ***If yes,*** any abnormalities? _____

INVESTIGATIONS FOR STROKE (MOTHER AND CHILD)

35. (i) Were any of the results of the following investigations abnormal? (*Please tick all that were abnormal*):

Mother	**Child**
☐ Activated Protein C Resistance (APCR)	☐ Activated Protein C Resistance (APCR)
☐ Anti-thrombin III (ATIII)	☐ Anti-thrombin III (ATIII)
☐ Fibrinogen	☐ Fibrinogen
☐ Plasminogen	☐ Plasminogen
☐ Protein S	☐ Protein S
☐ Protein C	☐ Protein C
☐ Factor V Leiden (FVL)	☐ Factor V Leiden (FVL)
☐ Methylenetetrahydrofolate Reductase (MTHFR)	☐ Methylenetetrahydrofolate Reductase (MTHFR)
☐ Prothrombin Gene	☐ Prothrombin Gene
☐ Homocysteine	☐ Homocysteine
☐ Factor VIII	☐ Factor VIII
☐ Factor IX	☐ Factor IX
☐ Factor XI	☐ Factor XI
☐ Lipoprotein (a)	☐ Lipoprotein (a)
☐ **Positive X 1** Anticardiolipin antibody (ACLA IgG)	☐ **Positive X 1** Anticardiolipin antibody (ACLA IgG)
☐ **Positive X 2** Anticardiolipin antibody (ACLA IgG)	☐ **Positive X 2** Anticardiolipin antibody (ACLA IgG)
☐ **Positive X 3** Anticardiolipin antibody (ACLA IgG)	☐ **Positive X 3** Anticardiolipin antibody (ACLA IgG)
☐ **Positive X 1 for** Lupus Anticoagulant	☐ **Positive X 1 for** Lupus Anticoagulant
☐ **Positive X 2 for** Lupus Anticoagulant	☐ **Positive X 2 for** Lupus Anticoagulant
☐ **Positive X 3 for** Lupus Anticoagulant	☐ **Positive X 3 for** Lupus Anticoagulant

(ii) Hypercoagulable disorder: ☐ Yes ☐ No ☐ DK ***If yes,*** Specify tests:_____

(iii) Known platelet aggregation disorder: ☐ Yes ☐ No ☐ DK ***If yes,*** Specify: _____

(iv) Any other haematological abnormality: ☐ Yes ☐ No ☐ DK ***If Yes,*** Specify: _____

TREATMENT/OUTCOME AT DISCHARGE (THIS CHILD)

36. (i) Did the child require respiratory support? ☐ Yes ☐ No ☐ DK ***If yes,*** ☐ CPAP ☐ Mechanical ventilation ☐ Other _____

(ii) Did the child undergo: Therapeutic cooling: ☐ Yes ☐ No ☐ DK; Surgical intervention:☐ Yes ☐ No ☐ DK; Neuroradiological intervention :☐ Yes ☐ No ☐ DK; ☐ Other; Specify _____

(iii) Did the child receive: Anticoagulation treatment ☐ Yes ☐ No ☐ DK ***If yes,*** Specify *(tick all that apply)*: ☐ Unfractionated heparin ☐ Low molecular weight heparin ☐ Aspirin ☐ Other; Specify _____

37. Outcome at discharge:

(i) Is the child alive? ☐ Yes ☐ No ☐ DK ***If No,*** date of death: __ __ /__ __ /__ __ __ __ (dd/mm/yyyy)

(ii) Did the child have any neurological deficits at discharge? ☐ Yes ☐ No ☐ DK **If yes,** Specify:_____

_____

Thank you for your help with this research project. Please return this questionnaire to the APSU via email (SCHN-APSU@health.nsw.gov.au) or fax to 02 9845 3082 even if you don't complete all items.

Australian Paediatric Surveillance Unit, Kid's Research Institute, Locked Bag 4001, Westmead NSW 2145.

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Sydney Medical School, The University of Sydney. 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.