Neonatal and Young Infant HSV Infection 12 Month Follow up Questionnaire (V1- 2017)

Australian Paediatric Surveillance Unit

If you have any questions about this form please contact the APSU (02) 9845 3005; SCHN-APSU@health.nsw.gov.au

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 1.0 11/11/2016

REPORTING CLINICIAN'S DETAILS **1.** APSU Dr Code/Name: __ __ ___ __ /_____ **2**. Date questionnaire completed: __ _/__ __/__ __ __ __

PATIENT DETAILS

3. First 2 letters of first name: __ __ **4.** First 2 letters of surname: __ __ **5.** Date of Birth: __ __ / __ __/ __ __ __ __

6. Sex: ☐ Male ☐ Female **7.** Postcode of family: __ __ __ 8. Month/Year of Initial Report __ __ / __ __ __ __

FOLLOW UP

9. Is the child still alive? Yes ☐ No ☐ DK☐

10. *If NO*: Date of death ☐☐/☐☐/☐☐

Cause of death: .....

11. *If YES,* Follow up (by yourself or others) since the primary HSV infection? Yes ☐ No ☐

12. *If YES*: Age at last visit: ☐☐ months

13. . Prophylactic antiviral prescribed? Yes ☐ No ☐ DK☐

If YES, Drug…… Dose .....mg/kg/day Route …… Duration: ☐☐ month(s)

Start Date (month/year) __ __ / __ __ __ __

OUTCOME (as assessed at last follow up):

14. Was neurological examination done? Yes ☐ No ☐ If yes: Normal ☐ Abnormal ☐

If Abnormal, please specify .....

15. Seizures Yes ☐ No ☐ DK☐

16. Developmental assessment Done? Yes ☐ No ☐ DK☐ If yes: ☐ Normal ☐ Abnormal

If Abnormal: ☐ mild ☐ moderate ☐ severe. Specify nature of impairment.....

17. Eye examination done? Yes ☐ No ☐ DK☐ If yes: Normal ☐ Abnormal ☐

18. Other physical/social sequelae of the neonatal HSV infection? Yes ☐ No ☐ DK☐

If yes: please specify .....

RECURRENCES

19. Recurrence of HSV disease? Yes ☐ No ☐ DK ☐ *If YES*, how many recurrences? ____

If NO, no further information is required. Thank you.

20. *If YES*: Site: Cutaneous ☐ Eye ☐ CNS ☐ Other ☐ Specify site .....

Management? *Please provide details of management for each of the recurrences. If there was more than 1 recurrence please print another questionnaire and complete the patient details and details of the additional recurrence.*

21. Hospital admission? Yes ☐ No ☐ DK☐ Name of Hospital…….

22. Antiviral therapy? Yes ☐ No ☐ DK☐ Drug used ..... Route..... Dose ..... mg/kg/day

23. Lumbar puncture performed? Yes ☐ No ☐ DK☐ If YES, Date: ☐☐/☐☐/☐☐

24. *If YES*: CSF HSV PCR: Positive ☐ Negative ☐ Not done ☐

CSF white cell count ☐☐☐☐ /mm^3 CSF red cell count ☐☐☐☐ /mm^3

25. HSV lesion/swab culture or PCR Yes ☐ No ☐ DK☐ Site ..... Result .....

Thank you for your help with this research project. Please return this questionnaire to the APSU in the reply-paid envelope or fax to 02 9845 3082. Australian Paediatric Surveillance Unit, Kids Research Institute, Locked Bag 4001, Westmead NSW 2145. This study is supported by a grant from the Australian Department of Health. This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.