Childhood Dementia Questionnaire
Australian Paediatric Surveillance Unit

Please return: (Using stamped addressed envelope) to –

Dr K.P. Nunn,
The Children's Hospital, P.O Box 34, Camperdown NSW 2050
Telephone: (02) 692-6548 Fax: (02) 692-6163

PAEDIATRICIAN

1. APSU Dr Code/Name: ☐☐☐☐/……

2. Address:……

3. Telephone:……**4.** Fax……

PATIENT DETAILS

5. Patient's first name (first two letters): ☐☐ **6.** Patient's family name (first two letters): ☐☐

7. Patient's date of birth (day, month, year): ☐☐ /☐☐ /☐☐

8. Post code of family: ☐☐☐☐

9. Country of birth of child: ……

1. How sure are you that this child has lost previously acquired skills related to brain dysfunction

Circle the appropriate scale point:

Extremely Unsure **Moderately Unsure** **Moderately Sure** **Extremely Sure**

2. What was the appropriate length of time between onset of the symptoms and diagnosis ?

a) < 3 months ☐
b) 3 months – 6 months ☐
c) > 6 months < 2 years ☐
d) 2 < 5 years ☐
e) 5 years and beyond ☐
f) Not known to me ☐
g) Information not available ☐
(e.g. child institutionalised with little history available)
h) Difficult to ascertain from the history ☐

3. Does the child have a sibling or siblings affected ? ☐ Yes ☐ No ☐ Uncertain

If Yes, specify the age of sibling ☐☐

4. Is the aetiology of the child's dementia known ? ☐ Yes ☐ No ☐ Uncertain

If Yes, what is the aetiology ? (See protocol for example)

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5. What clinical and diagnostic investigations are there to support this diagnosis ?

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6. If uncertain, what aetiologies are most likely and why ?

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……..

7. What is the overall impact of the child's condition on the family's day to day functioning ?

Minimally impairing	Moderately impairing	Markedly impairing	Extremely impairing

8. Please indicate the impact on each of the following family members

	MINIMAL	MODERATE	MARKED	EXTREME
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Non-affected sibs	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐
Marital Relationship	☐	☐	☐	☐
Don't know	☐	☐	☐	☐

9. How adequate are the current psychological support services for the needs of this child and the family ?

Very inadequate	Moderately inadequate	Moderately adequate	Very adequate

10. How much additional help at this time does the family require in the following areas ?

	MINIMAL	MODERATE	EXTREME
The physical care of the child	☐	☐	☐
Respite care	☐	☐	☐
Long term nursing care	☐	☐	☐
Terminal hospice care	☐	☐	☐
Supportive counselling for parents	☐	☐	☐
Supportive counselling for siblings	☐	☐	☐
Specialist Medical	☐	☐	☐

In which of these areas is help most urgently required ?

……

……

11. Would you be prepared to be contacted in 12 month's time for follow-up information ? ☐ Yes ☐ No

Thank you for filling out this questionnaire.Please contact if you have any difficulties completing it.