

**Vitamin K Deficiency Bleeding, including haemorrhagic disease of the new-born (HDN) Questionnaire - Australian Paediatric Surveillance Unit**

Please ring A/Prof Bin Jalaludin on 02 9828 6002 if you wish to discuss this questionnaire.

**PAEDIATRICIAN**

1. APSU Dr Code/Name /..... 2. Month/Year of Report...../.....  
3. Date questionnaire completed / /

**PATIENT DETAILS**

4. First 2 letters of surname  5. First 2 letters of first name   
6. Date of Birth  /  /  7. Sex  M  F  
8. Postcode of family   
9. Ethnic origin of mother  Caucasian  Aboriginal  Torres Strait Islander  Asian  Don't Know  
If other please specify: .....

**If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to APSU. Please keep the patient's name and other details in your records. 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:*

*Hospital:*

**Pregnancy and birth information**

10. Place of Birth  Hospital, please specify.....  Home  Other, please specify.....  
11. Type of Delivery  Normal  Instrument  Caesarean  Don't Know  
12. Gestational Age  weeks 13. Birth Weight:  gms  
14. During pregnancy did the mother take any anti-convulsants?  Yes  No  Don't Know  
If yes, please specify.....  
15. During pregnancy did the mother take any medications (apart from iron and vitamins tablets)?  
 Yes  No  Don't Know

If yes, please specify.....

**Vitamin K prophylaxis**

16. Was Vitamin K prophylaxis given at birth?  Yes  No  Don't Know  
If no, did the parents withhold consent?  Yes  No  Don't Know  
If yes, what was the mode of administration?  IM  IV  Oral  
Dose of Vitamin K? \_\_\_\_\_ mg  
Type of Vitamin K preparation?  Old Konakion (water soluble preparation) or  Konakion MM (new)  
When was the dose given? \_\_\_\_\_ (days since birth)
17. Was a second dose of Vitamin K given?  Yes  No  Don't Know  
If no, did the parents withhold consent?  Yes  No  Don't Know  
If yes, what was the mode of administration?  IM  IV  Oral  
Dose of Vitamin K? \_\_\_\_\_ mg. Type of Vitamin K preparation?  Old Konakion (water soluble preparation) or  Konakion MM (new). When was the dose given? \_\_\_\_\_ (days since birth)
18. Was a third dose of Vitamin K given?  Yes  No  Don't Know  
If no, did the parents withhold consent?  Yes  No  Don't Know  
If yes, what was the mode of administration?  IM  IV  Oral  
Dose of Vitamin K? \_\_\_\_\_ mg. Type of Vitamin K preparation?  Old Konakion (water soluble preparation) or  Konakion MM (new). When was the dose given? \_\_\_\_\_ (days since birth)
19. Were there any adverse effects attributable to Vitamin K prophylaxis?  Yes  No  Don't Know  
If yes, what effects were noted?  
.....  
When were these observed?  /  /  Date or Age of Child \_\_\_\_\_

**Clinical details**

20. First sign of bleeding/bruising  days since birth      21. Date of diagnosis  days since birth
22. Sites of bleeding/bruising?
- |                                  |                                                                                              |                             |                                     |
|----------------------------------|----------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------|
| Skin bruising                    | <input type="checkbox"/> Yes                                                                 | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Umbilical bleeding               | <input type="checkbox"/> Yes                                                                 | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Gastro-intestinal bleeding       | <input type="checkbox"/> Yes                                                                 | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Intra-cranial bleeding           | <input type="checkbox"/> Yes                                                                 | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Nose bleeds                      | <input type="checkbox"/> Yes                                                                 | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Prolonged oozing at Guthrie site | <input type="checkbox"/> Yes                                                                 | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Circumcision site                | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know | Other, please specify ..... |                                     |
23. Severity of bleeding (e.g. approx amount in mls) and therapy given .....

**Type of feeding**

24. Was the baby  solely breast fed since birth  primarily breast fed, but given some formula milk feeds  
 predominantly formula feeds?      If yes, name of formula?.....
25. Prior to presentation, had the infant
- |                                                            |                              |                             |                                     |
|------------------------------------------------------------|------------------------------|-----------------------------|-------------------------------------|
| Received any medication other than vitamin K since birth   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| If yes, please specify.....                                |                              |                             |                                     |
| Experienced diarrhoea, failure to thrive or other illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Experienced jaundice after the first week?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |

**Investigations/treatment**

26. Coagulation studies on presentation  Normal  Abnormal  Don't Know  Not Done  
 If abnormal, please specify exact values (including control values) \_\_\_\_\_
- Was the platelet count on presentation  High  Normal  Low  Don't Know  Not Done
27. Liver function tests on presentation  Normal  Abnormal  Don't Know  Not Done
28. Did the infant have liver disease?  Yes  No  Don't Know. If yes, please specify.....
29. Did the infant have evidence of sepsis?  Yes  No  Don't Know. If yes, please specify.....
30. Was Vitamin K given when bleeding/bruising occurred?  Yes  No  Don't Know  
 If yes, please specify dose of vitamin K and route of administration .....
31. Were coagulation studies performed after Vitamin K administered?  Yes  No  Don't Know. If yes, what were the coagulation studies after Vitamin K? Please specify exact values for INR/PT .....
32. Did Vitamin K correct the bleeding disorder clinically?  Yes  No  Don't Know
33. Was fresh frozen plasma given?  Yes  No  Don't Know  
 If yes, did this correct the bleeding disorder?  Yes  No  Don't Know
34. Was blood transfusion required?  Yes  No  Don't Know

**Outcome**

35. Infant Outcome  no ongoing morbidity  ongoing morbidity, please specify.....  
 prognosis unclear  Died  Don't Know
36. If the infant died, did HDN cause or contribute to the baby's death?  Yes  No  Don't Know
37. If the child's progress is unclear or the child experienced ongoing morbidity related to Vitamin K deficiency bleeding, would you be prepared to complete a short follow-up questionnaire on the infant's outcome in 12 months time?  Yes  No

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