

**Questionnaire About Patient with Congenital or Neonatal Varicella  
Notified to the Australian Paediatric Surveillance Unit**

**Please return to:**

Dr M Burgess  
The Children's Hospital, PO Box 34, Camperdown NSW 2050  
Telephone: (02) 519 0466 Fax: (02) 519 4282

**REPORTING PAEDIATRICIAN**

- 1. APSU Dr Code/Name  /.....
- 2. Month/Year of Report ..... /.....
- 3. Address: .....
- 4. Telephone: ..... Fax: .....

**PATIENT**

- 5. First 2 letters of first name
- 6. First 2 letters of surname
- 7. Date of Birth  /  /  Sex  M  F
- 8. City ..... State ..... Country .....of birth
- 9. Birth weight .....grams 10. Gestational age at birth .....weeks (if Known)

**PATIENT'S CLINICAL DETAILS:** Please tick the appropriate box

- 11. **Congenital varicella/embryopathy?** Yes  No  Not Known 
  - a) Skin scars or lesions? Yes  No  Not Known
  - b) Limb hypoplasia? Yes  No  Not Known
  - c) Eye lesions, microcephaly or other defect? Yes  No  Not Known   
Please specify .....
  - d) Developmental delay, failure to thrive etc? Yes  No  Not Known   
Please specify .....
  - e) Herpes zoster? Yes  No  Not Known   
Specify age.....
- 12. **Neonatal varicella?**
  - a) Give age when illness commenced .....days/weeks?
  - b) Approximate duration of illness (in days) .....
  - c) Severity: Mild  Moderate  Severe
  - d) Had infant received zoster immunoglobulin (ZIG)? Yes  No  Not Known   
Give age .....
  - e) Was there a history of varicella exposure? Yes  No  Not Known 
    - Intrauterine? Yes  No  Not Known
    - Postnatal? Yes  No  Not Known
    - Was the mother the source of the postnatal exposure? Yes  No  Not Known
  - f) Was the patient hospitalized? Yes  No  Not Known   
Give approximate number of days .....
- 13. Laboratory confirmation of diagnosis? Give age ..... Yes  No  Not Known   
Virus isolated  Varicella IgM+ve  Varicella IgG+ve
- 14. Is the patient still living? Yes  No  Not Known   
If not, date of death .....
- 15. Was an autopsy performed? Yes  No  Not Known
- 16. Was this a stillbirth or termination of pregnancy? Yes  No  Not Known

**MOTHER AND PREGNANCY**

- 17. If you do not know the answers to the following questions, is there another medical practitioner from whom we could obtain this information? Yes  No
- 18. Could you please provide the name and address of patient's obstetrician or general practitioner to whom we could send a questionnaire?.....  
.....
- 19. Mother's age when this child born (in years) .....
- 20. Affected child's rank in family eg. 1/3, 2/4, 1/1: .....
- 21. Did mother have a varicella contact in pregnancy? Yes  No  Not Known   
If yes, state stage of pregnancy in weeks from LMP .....
- 22. Was this contact living in the same household? Yes  No  Not Known
- 23. Did mother have a varicella-like illness – in pregnancy? Yes  No  Not Known   
Stage of pregnancy in weeks from LMP .....
- 24. Was the mother given zoster immunoglobulin (ZIG) in pregnancy? Yes  No  Not Known   
Stage of pregnancy in weeks from LMP .....
- 25. Serological confirmation of varicella in pregnancy? Yes  No  Not Known
- 26. Mother's country of birth .....
- 27. Mother's ethnicity .....
- 28. Father's country of birth .....

**THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE**