SEVERE NEONATAL HYPERBILIRUBINAEMIA OR EXCHANGE TRANSFUSION

Australian Paediatric Surveillance Unit

If you have any questions about this questionnaire please contact Dr Angela McGillivray on 0403 786298
or A/Prof Nick Evans on nevans@med.usyd.edu.au Tel: +612 9515 8760 Fax: +612 9550 4375 if you wish to discuss this

REPORTING CLINICIAN: 1. APSU Dr Code/Name:☐☐☐☐ /________________________________

2. Month/Year of Report:____/___ **3.** Date questionnaire completed: ☐☐/☐☐/☐☐

PATIENT DETAILS: 4. First 2 letters of first name: ☐☐ **5.** First 2 letters of surname: ☐☐

6. Date of Birth: ☐☐/☐☐/☐☐ Time of Birth: _____(24 hr clock) **7.** Sex: ☐ M ☐ F **8.** Postcode of family: ☐☐☐☐

9. Child's Ethnicity: ☐Aboriginal ☐Torres Strait Islander ☐Both Aboriginal and Torres Strait Islander
☐Caucasian ☐Asian ☐Pacific Islander ☐Middle Eastern ☐African ☐Other __________

10. Child's skin colour: Fair ☐ Dark ☐ Oriental ☐

11. Parents' country of birth: Mother ________________________ Father ________________________

***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:**

Instructions: Answer each question by ticking the appropriate box or writing your response in the space provided. DK= Don't Know, NA = Not applicable

PERINATAL INFORMATION

12. Gestation _________weeks ☐ DK **13.** Birthweight __________grams ☐ DK

14. Antenatal management of Rhesus disease? ☐Yes ☐No ☐DK

If yes, details please: ____

15. Mode of delivery: ☐Vaginal ☐Vaginal breech ☐Ventouse ☐Forceps ☐Caesarean

16. Where did the birth take place: ☐Hospital ☐Home

17. Apgar scores: 1 minute:__ 5 minutes:___ 10 minutes:___ **18.** Arterial cord gas result ***if available***:pH__Base deficit__

19. Marked bruising *eg. large cephalohaematoma*: ☐Yes ☐No ☐DK

If yes, please give details ____

20. Mode of feeding in first 2 weeks: ☐Breast only ☐Formula only ☐Combination

Describe timings if mode of feeding has changed______________________________________

PRESENTATION and DIAGNOSIS

21. Was this infant re-admitted with jaundice after initially being discharged? ☐Yes ☐No ☐DK ***If No Pls go to Q27***

If yes, date of initial discharge: ☐☐/☐☐/☐☐

If initially discharged from hospital **before** 48 hours old, please give hours of age at discharge:____________

22. What kind of post discharge surveillance was there after initial discharge?

☐None ☐Hospital Based Midwifery Discharge Support ☐GP

☐Community Based Nursing or Midwifery Support ☐Paediatrician ☐Other (Specify):_____________________

23. Time and date of re-admission Date ☐☐/☐☐/☐☐ Time: ___________(24 hr clock)

24. Source of referral for the re-admission:

☐Hospital Based Midwifery Discharge Support ☐GP

☐Community Based Nursing or Midwifery Support ☐Paediatrician

☐Self referred ☐Other (Specify):_________________________

25. Weight on re-admission:________ (grams) ☐Not weighed ☐DK

26. Dehydrated on re-admission ☐Yes ☐No ☐DK Plasma sodium _______mmol/L ☐Not measured ☐DK

DIAGNOSIS

27. Date and time of diagnosis of severe hyperbilirubinaemia: ☐☐/☐☐/☐☐ Time: ___________(24 hr clock)

28. How was diagnosis confirmed? ☐Total serum bilirubin ≥ 450μmol/L ☐Need for exchange transfusion
☐Retrospective diagnosis on basis of MRI changes?
☐Retrospective diagnosis on basis of clinical kernicterus?

29. Clinical features at time of severe hyperbilirubinaemia:

Lethargy and poor feeding: ☐Yes ☐No ☐DK Hypotonia: ☐Yes ☐No ☐DK

Opisthotonus: ☐Yes ☐No ☐DK Convulsions: ☐Yes ☐No ☐DK

Other (Specify)____

30. Highest Bilirubin result recorded for this infant: ________ μmol/L

31. Total duration of elevated bilirubin ≥ 450 μmol/L: _______(hrs and minutes)

32. Serum bilirubin results **PRE TREATMENT(**µmol/L). Please include ***all results*** before any treatment was commenced. ***Please attach de-identified printout of all serum bilirubin results if available.***

DATE	***TIME (24 hr clock)***	***TOTAL BILIRUBIN µmol/L***	***DATE***	***TIME (24 hr clock)***	***TOTAL BILIRUBIN µmol/L***

33. Serum bilirubin results **POST TREATMENT(**µmol/L). Please include ***all results*** after treatment commenced. ***Please attach de-identified printout of all serum bilirubin results if available***.

DATE	***TIME (24 hr clock)***	***TOTAL BILIRUBIN µmol/L***	***DATE***	***TIME (24 hr clock)***	***TOTAL BILIRUBIN µmol/L***

34. Associated dehydration with hyperbilirubinaemia? ☐Yes ☐No ☐DK
Plasma sodium _______mmol/L ☐Not measured Date ☐☐/☐☐/☐☐ Time: ___________(24 hour clock)
35. Did the infant have associated culture positive systemic infection? ☐Yes ☐No ☐DK
If Yes, SITE: ___________________________ ORGANISM: ____

36. Lowest albumin level______ g/l Date ☐☐/☐☐/☐☐ Time: ___________(24 hour clock) ☐Not measured ☐DK

37. Lowest blood pH ________ Date ☐☐/☐☐/☐☐ Time: ___________(24 hour clock) ☐Not measured ☐DK

38. Did the infant have other serious morbidity? ☐Yes ☐No ☐DK ***If Yes,*** Please specify (*eg. hypoxic-ischaemic encephalopathy, hypoglycaemia, liver disease)*____

39. Cause of hyperbilirubinaemia: ☐Physiological

☐ABO incompatibility: ☐Probable (Coombs positive) ☐Possible (Coombs negative)

☐Rhesus isoimmunisation ☐Glucose-6-phosphate dehydrogenase deficiency
☐Other ____

MANAGEMENT

40. Phototherapy used? ☐Yes ☐No ☐DK ***If Yes***, please record times and dates:

DATE	***Start (24 hr clock)***	***End (24 hr clock)***	***DATE***	***Start (24 hr clock)***	***End (24 hr clock)***

41. Albumin infusion? ☐Yes ☐No ☐DK ***If yes,*** time and date commenced______________________

42. Immunoglobulin infusion ☐Yes ☐No ☐DK ***If yes***, number of doses __________

43. Exchange transfusion ☐Yes ☐No ☐DK ***If yes***, how many ________________
Time and dates ____

44. Was magnetic resonance imaging brain scan done? ☐Yes ☐No ☐DK ***If Yes***, Date ☐☐/☐☐/☐☐ and Result:

☐Normal ☐Increased signal on T2-weighted images in globus pallidus

☐Abnormal but not consistent with bilirubin toxicity, (specify): ______________________________________

☐Other: (specify): ____

OUTCOME

45. Did the baby survive ☐Yes ☐No ☐DK ***If Yes,*** date of discharge:☐☐/☐☐/☐☐
Serum bilirubin closest to discharge: _____ µmol/L Neurological status normal at discharge? ☐Yes ☐No ☐DK
Hearing screen done? ☐Yes ☐No ☐DK ***If Yes,*** Result:____

If baby died, date of death: ☐☐/☐☐/☐☐ Was a post-mortem conducted ☐Yes ☐No ☐DK
If Yes, did the post-mortem show kernicterus ☐Yes ☐No ☐DK Or other associated pathology ☐Yes ☐No ☐DK
If Yes, (specify): ____

FOLLOW UP TRACKING INFORMATION

Please provide details of the physician from whom follow-up information can be obtained:
Please print Name:________________________ Phone No:______________ E-mail:________________
Do you have any other comments about this infant?

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THANK YOU FOR COMPLETING THIS QUESTIONNAIRE **Please return this questionnaire in the addressed reply-paid envelope to:**
Dr Angela M[c]Gillivray, Clinical Neonatology Fellow, Newborn Care, Royal Prince Alfred Hospital, Missenden Rd, Camperdown, NSW 2050, Australia.