Neonatal and Young Infant HSV Infection Questionnaire

Australian Paediatric Surveillance Unit

If you have any questions about this form please contact APSU at email 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 1.1: Date 10.12.2025

REPORTING CLINICIAN'S DETAILS

1. APSU Dr Code/Name: __ __ __ __ /_____

Provide your best organisational email address: _____

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. Racial Background *(select all that apply)*: ☐ Aboriginal ☐ Caucasian ☐ Pacific Islander ☐ Torres Strait Islander ☐ African ☐ Asian ☐ DK ☐ Other *(specify):* _____

9. Country of birth of the child: ☐ Australia ☐ Other *(specify)*: _____

10. Did you make the diagnosis of primary HSV infection? ☐ Yes ***(please go to Q11)*** ☐ No

If this patient is primarily cared for by another physician who you believe could provide additional details, please write their name below and return this form to the APSU. If no other report is received for this child we will contact you for further information.

Physician's Name: _____ Clinic/hospital: _____

11. Date patient first seen by you: __ __ / __ __ / __ __ __ __

MATERNAL

12. Mother's age in years: ☐☐

13. Mother's country of birth: ☐ Australia ☐ Other *(specify):*_____

14. Number of previous pregnancies: _____

15. Number of previous deliveries: _____

BIRTH DETAILS

16. Birth weight (grams): ☐☐☐☐

17. Gestational age at birth: ☐☐ completed weeks

18. Multiple Birth? ☐ Yes ☐ No ***If yes***, specify birth order (e.g. Twin 2) _____

19. Delivery: ☐ Vaginal - no instruments ☐ Instrumental vaginal ☐ Caesarean

20. Time between membrane rupture and delivery: ☐☐ hours ☐ DK

21. Was a scalp monitor applied? ☐ Yes ☐ No ☐ DK

22. Age baby first saw a doctor with manifestations of possible HSV infection ? ☐☐ months ***or*** ☐☐ days

CLINICAL MANIFESTATIONS IN THE INFANT

23. Please indicate where (in which system) clinical signs were noted and age (in days) when these first manifested

			Age of onset (months or days)	
(a) Skin, or Mouth	☐ Yes	☐ No	☐☐ months	☐☐ days

(b) Eyes	☐ Yes	☐ No	☐☐ months	☐☐ days
(bi) Seizures,	☐ Yes	☐ No	☐☐ months	☐☐ days
(bii) Irritability	☐ Yes	☐ No	☐☐ months	☐☐ days
(biii) Lethargy	☐ Yes	☐ No	☐☐ months	☐☐ days
(biv) Apnoea	☐ Yes	☐ No	☐☐ months	☐☐ days
(c) Respiratory (e.g. pneumonitis)	☐ Yes	☐ No	☐☐ months	☐☐ days
(d) Hepatic (ie: elevated liver function tests, jaundice)	☐ Yes	☐ No	☐☐ months	☐☐ days
(e) Bleeding or DIC	☐ Yes	☐ No	☐☐ months	☐☐ days
(f) Cardiac (e.g. hypotension, poor perfusion)	☐ Yes	☐ No	☐☐ months	☐☐ days
(g) Fever (>37°C)	☐ Yes	☐ No	☐☐ months	☐☐ days
(h) Other (specify)	☐ Yes	☐ No	☐☐ months	☐☐ days

INVESTIGATIONS ON INFANT

If these specimens were sent please complete the results (DK = Don't Know)

24. HSV typing (on any sample)?	☐ HSV 1	☐ HSV 2	☐ Not done	☐ DK	
25. HSV PCR positive surface swab or respiratory?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) _____
26. HSV CSF PCR positive?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) _____
27. HSV Blood PCR positive?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) _____
28. HSV Immunofluorescence positive?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) _____
29. HSV Isolated on Viral culture?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) _____

OTHER CSF EXAMINATION RESULTS?

30. Was a lumbar puncture performed at diagnosis? ☐ Yes ☐ No ☐ DK ***If Yes,*** Date _____ /_____ /_____

31. ***If YES***, Number of CSF white cells/mm^3 : ☐☐☐☐☐

Number of CSF red cells/mm^3 : ☐☐☐☐☐

TREATMENT, FOLLOW UP INVESTIGATIONS, AND PROPHYLAXIS OF THE INFANT

32. Was the baby treated for HSV infection? ☐ Yes ☐ No ☐ DK ***If Yes,*** please provide details:

DRUG Used	Age when started		Dose mg/ kg/ per/ day	Route	Duration (days)
	months	days			

33. Were antiviral drugs given as prophylaxis to prevent recurrence after treatment course completed? ☐ Yes ☐ No ☐ DK ***If Yes,*** please provide details:

DRUG Used	Age when started		Dose mg/ kg/ per/ day	Route	Duration (days)
	months	days			

34. Was a lumbar puncture performed at the end of antiviral therapy? ☐ Yes ☐ No ☐ DK ***If Yes,*** Date _____ /_____ /_____

35. If YES, Number of CSF white cells/mm^3 ☐☐☐☐☐

Number of CSF red cells/mm^3 ☐☐☐☐☐

CSF HSV PCR result: ☐ Positive ☐ Negative ☐ Not Done

36. Convalescent CSF HSV IgG and IgM: *(specify result)* _____ Date _____ /_____ /_____

CEREBRAL IMAGING /EEG ON INFANT

37. CNS imaging performed? ☐ Yes ☐ No

38. ***If Yes***, CNS Imaging modality: ☐ Ultrasound ☐ CT scan

39. CNS Imaging result: ☐ MRI scan ☐ Other *(specify):* _____ ☐ Normal ☐ Abnormal ☐ Not Done Date of scan ☐☐/☐☐/☐☐

Please specify result: _____

40. EEG performed? ☐ Yes ☐ No

41. ***If Yes***, EEG Results: ☐ Normal ☐ Abnormal

Date of scan ☐☐/☐☐/☐☐

Please specify result: _____

OUTCOME AT THIS PRESENTATION

42. Infant: survived? ☐ Yes ☐ No

43. If died, Date of death: ☐☐/☐☐/☐☐

44. If survived, were there obvious sequelae at discharge: ☐ Yes ☐ No ☐ DK

If yes, please specify: _____

SOURCE OF INFECTION

Genital Herpes	**Mother**	**Father**	**Other maternal sexual partner**
45. No known genital herpes at any time	☐	☐	☐
46. Genital herpes before (& during) this pregnancy	☐	☐	☐
47. Genital herpes during this pregnancy for first time	☐	☐	☐
48. Genital herpes diagnosed first time after delivery	☐	☐	☐
49. Other: _____	☐	☐	☐

Non-Genital Herpes	**Mother**	**Father**	***Other (please specify)**
50. Past history of non genital herpes (oral or whitlow)	☐	☐	☐ _____
51. Oral herpes at or soon after delivery	☐	☐	☐ _____
52. Herpetic whitlow at or soon after delivery	☐	☐	☐ _____

**other = contact other than parent eg; Hospital staff /Sibling/Relative.*

53. Was Maternal antiviral therapy given during pregnancy? ☐ Yes ☐ No ☐ DK

54. ***If Yes,*** please provide details:

DRUG Used	Dose mg/ kg/ per/ day	Route	Duration (days)

MATERNAL INVESTIGATIONS:

55. Was the mother's HSV type specific antibody status tested? ☐ Yes ☐ No

If Yes

a) HSV-1 IgM ☐ Positive ☐ Negative ☐ Indeterminate Date ____/____/_____

b) HSV-1 IgG ☐ Positive ☐ Negative ☐ Indeterminate Date ____/____/_____

c) HSV-2 IgM ☐ Positive ☐ Negative ☐ Indeterminate Date ____/____/_____

d) HSV-2 IgG ☐ Positive ☐ Negative ☐ Indeterminate Date ____/____/_____

Thank you for your assistance with this research project

Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au or via Fax: (02) 9845 3082

or by mail to: Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Faculty of Medicine and Health, The University of Sydney.

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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines