Congenital Adrenal Hyperplasia Questionnaire
Australian Paediatric Surveillance Unit

Survey form B – for patients diagnosed after 6 months age

PAEDIATRICIAN

1. APSU Dr Code/Name: ☐☐☐☐/……

2. Report code ☐☐/☐☐

3. Address:……

4. Telephone:……**5.** Fax……..

PATIENT DETAILS

6. Surname (first two letters only): ☐☐ **7.** First name (first two letters only) : ☐☐

8. Date of birth (day, month, year) : ☐☐/☐☐/☐☐ **9.** Sex : ☐ Male ☐ Female

10. Post code of family : ☐☐☐☐

11. Ethnic origin of mother : ☐ Caucasian ☐ Other (please specify)

12. Ethnic origin of father : ☐ Caucasian ☐ Other (please specify)

Features at diagnosis

13. Age at diagnosis ☐☐/☐☐

14. Features of initial presentation (please indicate which of these were present at initial presentation ,more than 1 may apply):

☐ Genital anomalies / ambiguous genitalia

☐ Virilization without genital ambiguity

☐ Abnormal growth

☐ Asymptomatic , detected during screening of family members

☐ Other (please specify)……..

15. Was the child treated for an alternative diagnosis prior to confirmation of CAH ☐ Yes ☐ No

If Yes, please specify ……

16. Bone age at presentation ☐☐ Years ☐☐ Months

Bone age method: ☐ Greulich and Pyle

☐ Tanner-Whitehouse

☐ Other (please specify)……

17. Height at presentation ☐☐☐ cm

18. History of CAH in a sibling ☐ Yes ☐ No

19. No of affected siblings ☐☐

Laboratory features

20. Biochemical diagnosis in this patient

☐ 21-hydroxylase deficiency

☐ Other adrenal enzyme deficiency (please specify)……..

Laboratory features (Continued)

☐ Not yet available

***21 – 26. Biochemistry at presentation (if performed)**

21. Plasma renin activity …….. mmol/L Lab normal range and units ……

22. ACTH …….. pmol/L Lab normal range and units ……

23. Serum testosterone …….. nmol/L Lab normal range and units ……

24. Other androgens (if performed, please specify value and units and normal lab ranges) ……

……

25. 17-hydroxyprogesterone (17-OHP) …….. nmol/L Lab normal range and units

17-OHP lab normal range:……

26. If a synacthen test was performed, please indicate steroids measured and results:

……..

……

Selected management aspects

27. Age at commencement of treatment ☐☐/☐☐ (years / months)

28. Continuing therapy

Glucocorticoid ☐ Yes ☐ No **If Yes, please specify type ……**

Mineralcorticoid ☐ Yes ☐ No

If more convenient, a deindentified laboratory printout of results could be provided

Please return the questionnaire in the reply-paid envelope to Dr Geoff Ambler, Institite of Endocrinology, The Children's Hospital, Camperdown, 2050. Phone 02 692 6464, Fax 02 516 4781.

Thank you for your assistance