Paediatric Hepatitis C Virus (HCV) Questionnaire (V3-0305)
Australian Paediatric Surveillance Unit
Please ring A/Prof Cheryl Jones on (02) 9845 1902 if you wish to discuss this questionnaire.

REPORTING CLINICIAN

1. APSU Dr Code/Name ☐☐☐☐ /……2. Month/Year of Report …..… /…….

PATIENT

3. First 2 letters of first name ☐☐ 4. First 2 letters of surname ☐☐
5. Post code ☐☐☐☐ 6. Sex ☐M ☐F
7. Date of Birth: ☐☐/☐☐/☐☐
8. Country of Birth: Australia ☐ Other ☐, please specify .....
9. Date of patient's first positive HCV test: ☐☐/☐☐/☐☐
10. Date patient first seen by yourself: ☐☐/☐☐/☐☐

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. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

Please keep the patient's name and other details in your records.

Instructions: Please answer each question by placing a tick in the appropriate box or writing your response in the space provided. DK= Don't Know

CHILD'S RISK FACTORS FOR HCV INFECTION

11. Child born to HCV infected mother Yes ☐ No ☐ DK ☐
12. Child received transfusion of blood /blood product Yes ☐ No ☐ DK ☐ If YES date .../..../....
13. Organ transplant recipient Yes ☐ No ☐ DK ☐ If YES date .../..../....
14. Postnatal exposure to HCV through family member Yes ☐ No ☐ DK ☐
15. Child's intravenous drug use Yes ☐ No ☐ DK ☐
16. Child's tattoo/body piercing Yes ☐ No ☐ DK ☐
17. Other source of exposure (please specify) ……

HIV AND/OR HEPATITIS B(HEP B) CO-INFECTION IN CHILD

18. Does the child have HIV co-infection Yes ☐ No ☐ DK ☐
19. Does the child have Hepatitis B co-infection Yes ☐ No ☐ DK ☐

CHILD'S HISTORY

20. What was the child's mode of delivery
Vaginal delivery ☐ Assisted vaginal delivery ☐ Caesarean Section ☐ DK ☐
21. For how long was this child breast fed (full or supplementary feeds) ☐☐ month(s) DK ☐ Not applicable ☐

REASON FOR INVESTIGATION

22. What was the reason for investigating this child for HCV infection ……
……

MATERNAL HISTORY

23. a) Has the Mother had an HCV Antibody test Yes ☐ No ☐ DK ☐
b)If yes and mother's HCV Antibody positive, specify date of first positive HCV test: …../……/..... DK ☐
24. a) Has the mother had an HCV RNA test Yes ☐ No ☐ DK ☐
b) If yes and mother is HCV RNA positive, specify date of first positive HCV test: …../……/……. DK ☐
25. a) Does the mother have HIV co-infection Yes ☐ No ☐ DK ☐
b) If mother **is** HIV positive, what was the date of HIV diagnosis: ……/……/..... DK ☐
c) If mother has **not** a positive HIV test, what was the date of the last HIV test: . ..../……/..... DK ☐
26. Does the mother have Hepatitis B (HBV) co-infection Yes ☐ No ☐ DK ☐

KNOWN MATERNAL RISK FACTORS FOR HCV INFECTION

27. Maternal country of birth Australia ☐ Other, please specify…….. DK ☐

28. Maternal Intravenous drug use Yes ☐ No ☐ DK ☐

29. Mother received transfusion of blood /blood product Yes ☐ No ☐ DK ☐ IF YES date ……/……/.....

30. Mother at risk from other health care (e.g:surgery, transplant) Yes ☐ No ☐ DK ☐ IF YES specify ……

31. Mother's inhalant drug use? Yes ☐ No ☐ DK ☐

32. Mother's tattoo/body piercing? Yes ☐ No ☐ DK ☐

33. Mother experienced needlestick / biohazardous injury Yes ☐ No ☐ DK ☐ If YES date ……/……/.....

34. Mother is a health care worker? Yes ☐ No ☐ DK ☐

35. Mother is/was in prison? Yes ☐ No ☐ DK ☐

36. Specify any other source of maternal exposure to HCV …….

CHILD'S CLINICAL SYMPTOMS/SIGNS AT PRESENTATION

37. Symptomatic Yes ☐ No ☐ DK ☐

38. Lethargy Yes ☐ No ☐ DK ☐

39. Bruising Yes ☐ No ☐ DK ☐

40. Jaundice Yes ☐ No ☐ DK ☐

41. Hepatomegaly Yes ☐ No ☐ DK ☐

42. Signs of liver failure Yes ☐ No ☐ DK ☐

43. Failure to thrive Yes ☐ No ☐ DK ☐

44. Specify any other symptom/signs ……..

LABORATORY DIAGNOSIS OF CHILD'S HCV INFECTION

45. Has the child's HCV Antibody status been tested? Yes ☐ No ☐ DK ☐

IF YES a) Result of test 1 Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/.....

b) Result of test 2 Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/.....

46. Has the child's HCV RNA status been tested? Yes ☐ No ☐ DK ☐

IF YES a) Result of test 1 Positive ☐ Negative ☐ Date…../……/..... HCV Genotype .....

b) Result of test 2 Positive ☐ Negative ☐ Date…../……/….. HCV Genotype .....

LIVER FUNCTION TESTS

47. Have liver function tests been performed? Yes ☐ No ☐ DK ☐

If YES a) Most recent values: date …../……/…... AST ..... units ..... ALT ..... units ……..

b) Were the LFTs ever abnormal? Yes ☐ No ☐ DK ☐

c) What was the highest ALT value date? ….. ../……../……DK ☐

48. Has a liver biopsy been performed? Yes ☐ No ☐ DK ☐

If YES: a) Date of Biopsy ……./……./..... DK ☐

b) Result of biopsy DK ☐ Normal ☐ Abnormal ☐ (specify) …….

CHILD'S TREATMENT

49. Has HCV antiviral therapy been given for HCV infection? Yes ☐ No ☐ DK ☐

If YES: a) Date started ……./……./..... DK ☐

b) Indication for treatment …… DK ☐

c) Specify drug(s) DK ☐

Alpha interferon: ☐ dose ..... frequency ..... proposed duration .....

Ribavirin: ☐ dose ..... frequency ..... proposed duration .....

Other: ……..

Please return this questionnaire in the addressed reply-paid envelope to A/Prof Cheryl Jones, The Perinatal Infection Research Unit, c/- The Clinical School, The Children's Hospital at Westmead, Locked Bag 4001, Westmead, NSW 2145.

Thank you for your assistance with this study, which has been approved by a Human Ethics Committee. The APSU is a Unit of the Royal Australasian College of Physicians (Division of Paediatrics and Child Health) and is funded by the NHMCR (Enabling Grant No. 40284), the Department of Health and Ageing, and the Faculty of Medicine at the University of Sydney.