

NSHPC confidential paediatric notification

LONDON MREC/04/2/009

office use only

May 2005

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Paediatrician _____ Hospital _____

CONFIDENTIAL Please complete this form as far as you can, even if you do not have all details requested

A PAEDIATRIC DETAILS

NHS no Hospital no Initials Soundex

Date of birth ____/____/____ Male Female Home postcode (leave off last letter)

Ethnic origin White Black African Black Caribbean Black other
 Indian Subcontinent Oriental Other or mixed, specify

Born in UK/Ireland Hospital of birth Home postcode at birth (leave off last letter)
or Abroad Country of birth and date arrived in UK/Ireland ____/____/____

B HOW WAS THIS CHILD IDENTIFIED AS INFECTED OR AT RISK OF INFECTION?

Mother known to be infected in pregnancy Child symptomatic
 Mother/other family member found to be infected (specify relationship)
 NK Other, specify

Date of child's first lab investigation ____/____/____ not yet done tests refused NK

If you are aware of *siblings* reported to us, please give dates of birth or other ref:

C PERINATAL DETAILS

Mode of delivery vaginal elective CS emergency CS NK Gestation Birthweight

Any perinatal infections? No Yes, specify

Any congenital abnormalities? No Yes, specify

Any other problems? No Yes, specify

Anti-retroviral treatment for mother and/or baby to reduce risk of vertical transmission? No Yes, specify below

Antenatally? NK No Yes, specify

Intrapartum? NK No Yes, specify

Post-partum (baby)? NK No Yes, specify

Was the child breastfed? No Yes, and breastfed for how long? (wks) NK if breastfed

D PROBABLE SOURCE OF INFECTION

1. Exposed to maternal infection? Yes, please give *mother's* details below No, go to question 2 below NK

a) Mother's date of birth ____/____/____ b) No. of *previous* livebirths..... stillbirths..... miscarriages/terms.....

c) Mother's country of birth and if not UK/Ireland, date arrived ____/____/____

d) Mother diagnosed after the birth of this child while pregnant with this child before this pregnancy

e) Maternal infection probably acquired in UK/Ireland abroad, specify NK where and likely exposure (tick all that apply)

injecting drug use transfusion recipient
 sexual exposure, specify partner's probable risk factors if known
 mother to child transmission no information on mother's exposure

2. Other exposure risk for child? No Yes, please give details

blood/blood products abroad, please specify country and year
 sexual exposure other, please specify.....

E INFECTION STATUS & LABORATORY INVESTIGATIONS

Do you consider this child to be infected not infected indeterminate (definitions on next page)

If indeterminate and further laboratory investigations refused, please tick

Any evidence of type 2 infection? No Yes

	pos	neg	sample date	pos	neg	sample date
Antibody	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
PCR	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
Other test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___

specify test.....

Viral load copies/ml (..... log₁₀) type of test date ___/___/___

CD4.....% no. CD8.....% no. Total lymphocytes no. ___/___/___

F THERAPY (tick all that apply and give brief details)

PCP prophylaxis? No Yes, specify date started ___/___/___

Antiretroviral treatment for **infected** child? Not applicable (uninfected) No Yes, specify drugs below
 date treatment started ___/___/___

Child enrolled in clinical trial? No Yes, trial trial no. date enrolled ___/___/___

G CLINICAL DETAILS

Date of last examination ___/___/___ and, if taken at that time: Weight (kg) Height (cm)

Has the child had any CDC stage C symptoms? No Yes (See back page for definitions) **Diagnosis** **Date**
Comments Presumptive / Definitive mm/yy

Opportunistic infections, specify	<input type="checkbox"/>	<input type="checkbox"/>	___/___
Severe, symptomatic LIP	<input type="checkbox"/>	<input type="checkbox"/>	___/___
Severe recurrent bacterial infection.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___
Severe failure to thrive	<input type="checkbox"/>	<input type="checkbox"/>	___/___
Encephalopathy, specify	<input type="checkbox"/>	<input type="checkbox"/>	___/___
Neoplasms, specify	<input type="checkbox"/>	<input type="checkbox"/>	___/___

Has the child had any other symptoms related to the infection? No Yes (See next page for definitions)

Symptoms/signs	Initial onset (mm/yy)	Comments
Mild/asymptomatic LIP	___/___
Severe bacterial infection	___/___
Failure to thrive	___/___
Regression of milestones	___/___
Other related symptoms, specify	___/___

Any other serious infections or conditions? No Yes, specify

H FOLLOW UP STATUS

Date of last contact ___/___/___ Alive Lost to follow up Known to have left UK/Ireland
 Dead, date of death ___/___/___ and if dead

Certified cause a) disease or condition directly leading to death
 of death b) secondary cause(s)

Post-mortem? Not done Done. Please attach a copy if possible.

Completed by: Name _____ Position _____ Date ___/___/___

Tel no _____ Email _____

**Thank you for completing this form. Please return it to: Surveillance Studies Group,
 Centre for Paediatric Epidemiology & Biostatistics, Institute of Child Health, 30 Guilford Street, London WC1N 1BR.
 Call us with any queries on 020 7829 8686 or email nshpc@ich.ucl.ac.uk**