Acute Intussusception Questionnaire

Paediatric Active Enhanced Disease Surveillance Pilot Study

Instructions*: Please keep the Patient's name, MRN and other details in your records.** * Mandatory Fields***

ADMISSION DETAILS

1. Hospital Code: ☐☐☐-☐☐☐☐ 2. PAEDS Database Record No. (Intuss): _____

3. *Notification Date: ☐☐/☐☐/☐☐ 4.*Date of Admission: ☐☐/☐☐/☐☐

5. If transferred, hospital transferred from _____ 6.Date of Admission at referring hospital ☐☐/☐☐/☐☐

PATIENT DETAILS

7. *First 2 letters of first name: ☐☐ 8. *First 2 letters of surname: ☐☐

9. *Date of Birth: ☐☐/☐☐/☐☐ 10.*Sex: ☐ M ☐ F

11. Postcode of family: ☐☐☐☐

RECRUITMENT PROCESS

12. Patient screened: Yes ☐ No ☐ 13. Received consent: Yes ☐ No ☐

14. Status: Confirmed ☐ Didn't meet criteria ☐ **If excluded, please specify reason:** _____

PATIENT HISTORY

15. Birth Weight: ____(grams) 16. Gestational age: Term ☐ Pre-term (<37 weeks) ☐ **If pre-term,** please state corrected age _____ DK ☐

17. Country of Birth: Australia ☐ Other ☐ **If other, specify**_____ ☐ DK

18. Ethnicity: ATSI ☐ Caucasian ☐ Asian ☐ Pacific Islander ☐ Middle Eastern ☐ African ☐ Other ☐

If other, please specify _____

19. Date of admission for the current episode of Intussusception: ☐☐/☐☐/☐☐

20. Has the patient had Intussusception before? Yes ☐ No ☐ DK ☐

If yes, a) how many previous episodes? _____ b. At what age(s) (months)? _____

21. Is there any known history of Intussusception in the family? Yes ☐ No ☐ DK ☐

22. Has the patient had any previous significant illnesses / hospitalisations / operations? Yes ☐ No ☐ DK ☐

If yes, a) specify age at which illness took place _____ months

b) and specify type of illness/operation: _____

VACCINATION HISTORY

23. Has the patient ever been vaccinated? Yes ☐ No ☐ DK ☐

24. Has the patient ever received a **rotavirus vaccine**? Yes ☐ No ☐ DK ☐

If yes, a) specify type of vaccine and manufacturer ☐ Rotarix®, GSK ☐ Rotateq®, Merck

b) specify date: Dose 1: ☐☐/☐☐/☐☐ Dose 2: ☐☐/☐☐/☐☐ Dose 3: ☐☐/☐☐/☐☐

25. Has the child received any other vaccines within the last 4 weeks? Yes ☐ No ☐ DK ☐

If yes, list all **other vaccines** given in the last **4 weeks** before current episode of IS

Vaccine Type	Vaccine Brand	Birth Dose	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Other Doses
DTaP			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Polio			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hep B		__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hib			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Pneumoccocal Conjugate			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Meningococcal			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
MMR			__/__/__	__/__/__				__/__/__
Varicella			__/__/__	__/__/__				__/__/__
Influenza			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
dTap			__/__/__					__/__/__
Other 1			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Other 2			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Other 3			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

26. Source of patient's vaccination history Child Health Record ☐ ACIR ☐ Council ☐ Parent Recall ☐ Other ☐
If other, please specify_____

27. Has this case been reported to ADRAC as an adverse event? Yes ☐ No ☐ DK ☐

If yes, please specify i) Name of reporter_____ ii) Date of report ☐☐/☐☐/☐☐

MEDICATIONS/TRADITIONAL MEDICINES

28. Is the child currently receiving treatment? Yes ☐ No ☐ DK ☐
If yes, please list all medications received within the last week and currently

Date	Medication	Dose

FEEDING HISTORY

29. What is the patient currently fed? (*Tick as many as apply*) Breast milk ☐ Formula ☐ Solids ☐ Other ☐
If other, please specify _____

30. If breast-fed, until what age was the patient exclusively breast-fed? _____ months **Please indicate:** :Still feeding ☐ N/A ☐

31. Has there been any change to the patients' diet in the last week? Yes ☐ No ☐ DK ☐
If yes, specify_____

32. Has the patient had any feeding intolerance/food sensitivities? Yes ☐ No ☐ DK ☐ **If yes,** please describe (eg. egg - rash) _____

CLINICAL DETAILS OF INTUSSUSCEPTION EPISODE

33. How was the diagnosis of Intussusception made? (*tick >1 if relevant*)

Enema ☐ Ultrasound ☐ Abdominal X-ray ☐ Other ☐ Surgery ☐

Site of IS (eg. Ascending colon) _____

Type of IS (eg. Ileocaeal) _____

34. What was the duration of symptoms prior to diagnosis?

<12 hours ☐ 12-23hours ☐ 24-48 hours ☐ 49-72 hours ☐ >72hours ☐ Unknown ☐

35. Please indicate which of the following symptoms or signs were present at the time of diagnosis or in the week prior to diagnosis (*tick as many as apply*).

☐ Intestinal Obstruction ⇒	**Please specify:** ☐ Bile Stained Vomiting ☐ Acute Abdominal Distension ☐ Abnormal or absent bowel sounds ☐ Abnormal XR: Fluid level + dilated loops
☐ Features of Intestinal invagination⇒	**Please specify:** ☐ Intestinal mass ☐ Rectal mass ☐ Intestine prolapse ☐ Plain abdominal XR showing IS ☐ CT showing IS
☐ Intestinal vascular compromise or venous congestion ⇒	**Please specify:** ☐ Passage of blood per rectum ☐ Passage of "red current jelly" stool ☐ Blood on rectal examination
Other symptoms (Please specify)	
☐ Abdominal pain ☐ Vomiting ☐ Lethargy ☐ Pallor ☐ Hypovolaemic shock ☐ Plain XR abnormal – non specific, bowel gas ☐ Fever – temp:_____ ^{o}C ☐ Diarrhoea	☐ Irritability ☐ Shortness of breath or ☐ Abnormal breath sounds ☐ Rash ☐ Urticaria ☐ Headache ☐ Focal neurological signs ☐ Paralysis ☐ Seizures ☐ Other **If other, please specify**_____

36. Does this episode fulfill the Brighton Collaboration case definition of acute intussusception Yes ☐ No ☐ DK ☐
If yes, specify level: Definite ☐ Probable ☐ Possible ☐

Treatment and Outcome

37. What was the successful method of treatment?

Air/hydrostatic Enema ☐ ⇒ **Specify if** Ultrasound guided ☐ Fluoroscopy guided ☐
Surgery ☐ ⇒ Resection ☐ ⇒ Length of bowel resected _____cm
Other ☐ ⇒**If Other ,specify**_____

37a. Lead point or other pathology identified? Yes ☐ No ☐ DK ☐
If yes, describe_____

38. Discharge status? Discharged ☐ Died ☐ 38a.If discharged, what was the date of discharge ? ☐☐/☐☐/☐☐

38b. If died, what was the date of death ? ☐☐/☐☐/☐☐

Samples – Please send stool samples to: Local laboratory

39. Stool sample collected? Yes ☐ No ☐ **If no why?** _____
If yes, please give date collected: ☐☐/☐☐/☐☐

40. What was the result? _____

41. ICD-10-AM diagnosis codes _____
_____

42. Additional comments
_____
_____
_____