Hospitalised Infantile Seizures in Children Greater Than One Month & Less Than 8 Months of Age
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 (Seizures): _____
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: ☐☐☐☐ 12. Country of Birth: Australia ☐ Other ☐ specify _____ ☐ DK
13. Ethnicity: ATSI ☐ Caucasian ☐ Asian ☐ Pacific Islander ☐ Middle Eastern ☐ African ☐ Other ☐
If other, please specify) _____
14. Gestational age: Term ☐ Pre-term (<37 weeks) ☐ **If pre-term,** please state corrected age at time of admission……DK ☐
15. Birth Weight: _____(grams) 16. Current weight: _____ (grams) 17. Current HC _____ (cm)

RECRUITMENT PROCESS

18. Patient screened: Yes ☐ No ☐ 19. Received consent: Yes ☐ No ☐
20. Status: Confirmed ☐ Didn't meet criteria ☐ **If excluded, please specify reason:** _____

PATIENT HISTORY

21. Was the patient developmentally normal prior to seizure onset? Yes ☐ No ☐ Unsure ☐
If no, please specify_____
22. At what age was the patient?
a) Smiling At age _____ weeks ☐ Not Yet c) Rolling back to front At age_____months ☐ Not Yet
b) Sitting At age _____ months ☐ Not Yet d) Rolling front to back At age_____months ☐ Not Yet
23. Did the patient have a pre-existing disease (eg head injury, pre-term IVH or chromosome abnormality) Yes ☐ No ☐
If yes, please specify_____
24a) Is there a family history of a seizure disorder? Yes ☐ No ☐ Unsure ☐
If yes, please specify relationship Parent ☐ Sibling ☐ Other ☐ **If other,** please specify _____
b) Type of seizure (Tick one or more boxes): Generalised ☐ Tonic clonic ☐ Tonic ☐ Clonic ☐ Atonic ☐ Focal ☐
Secondary generalised ☐ Myoclonic ☐ Febrile ☐ Other ☐ **If other,** please describe_____

VACCINATION HISTORY

25. Has the patient ever been vaccinated? Yes ☐ No ☐ DK ☐
If yes, list all **vaccines** and dates given

Vaccine Type	Vaccine Brand	Birth Dose	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Other Doses
DTaP			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
P o l i o			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hep B		__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hib			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Pneumoccocal Conjugate			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/_
Rotavirus			__/__/__	__/__/__	__/__/__	__/__/_	__/__/__	__/__/__
Meningococcal			__/__/__	__/__/__	__/__/__	__/__/_	__/__/__	__/__/__
Influenza			__/__/__	__/__/__	__/__/__	__/__/_	__/__/__	__/__/__
d T a p			__/__/__					__/__/__
Other 1			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Other 2			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Other 3			__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

26. What was the time interval between vaccination and seizure onset?
<12 hours ☐ 12-23hours ☐ 24-48 hours ☐ 49-72 hours ☐ >72hours ☐ Unknown ☐
27. Source of patient's vaccination history Child Health Record ☐ ACIR ☐ Council ☐ Parent Recall ☐ Other ☐
If other, please specify_____
28. 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 ☐☐/☐☐/☐☐

CLINICAL FEATURES ON ADMISSION

29. Date of onset of seizure (dd/mm/yy)? ☐☐/☐☐/☐☐

30. Was the patient acutely unwell prior to seizure onset? Yes ☐ No ☐ Unsure ☐
If yes, specify _____
_____

31. Did the patient have a fever >38 °C prior to the seizure? Yes ☐ No ☐ Unsure ☐
If yes, what was the highest temperature recorded? ☐☐.☐ °C Time and date of temperature …. …. ☐☐/☐☐/☐☐

32. What was the patient's temperature recorded on admission? ☐☐.☐ °C

33. Did the patient have a fever >38 °C following admission? Yes ☐ No ☐ Unsure ☐
If yes, what was the highest temperature recorded? ☐☐.☐ °C Time and date of temperature …. …. ☐☐/☐☐/☐☐

34. Please describe the clinical features of the seizure (tick one or more boxes)

a) Type of seizure (Tick one or more boxes): Generalised ☐ Tonic clonic ☐ Tonic ☐ Clonic ☐ Atonic ☐ Focal ☐
Secondary generalised ☐ Myoclonic ☐ Loss of consciousness: witnessed ☐ Loss of consciousness: NOT witnessed ☐
Other ☐ **If other,** please describe_____

b) Duration of seizure: <5 min ☐ 5-10 min ☐ 10-30 min ☐ 30-60 min ☐ >60 minutes ☐

c) Did the initial seizure require medication for cessation? Yes ☐ No ☐ Unsure ☐
If yes, specify medication and dose _____

d) Number of seizures during 48hrs following admission (or during admission if < 48 hours): None ☐ 1 ☐ 2 ☐ 3-10 ☐ >10 ☐

INVESTIGATIONS

35. Were there other clinical or laboratory features that confirmed the diagnosis (eg: MRI radiology, EMG) please specify)

1.C.S.F :				
a) glucose	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
b) micro	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
c) lactate	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
d) other	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
2.Ca/Mg/PO4	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
3.Blood Sugar Level	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
4 Metabolic screen :				
a) Blood	Normal ☐	Abnormal ☐	**If abnormal,** please specify : i) lactate _____ ii) pyruvate _____	Not done ☐
b) Urine	Normal ☐	Abnormal ☐	**If abnormal,** please specify : i) amino acid profile _____ ii) organic acid profile _____	Not done ☐
5.EEG	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
6. Cerebral Imaging :				
a) Ultrasound	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
b) MRI	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
c) C.T.	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
d) Other	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
7.Genetic	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
8. Micro :				
a) Blood	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
b) Urine	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
c) Other	Normal ☐	Abnormal ☐	**If abnormal,** please specify _____	Not done ☐
9. Other _____				

INVESTIGATIONS

36. Was the patient admitted to the intensive care unit? Yes ☐ No ☐

If yes, please give number of days ☐☐☐

DIAGNOSIS

37. What was the patient's final diagnosis?_____

_____

_____

OUTCOME OF THIS EPISODE

38. What is the patient's discharge status? Discharged ☐ Died ☐

If discharged, what was the date of discharge ? ☐☐/☐☐/☐☐

If died, what was the date of death ? ☐☐/☐☐/☐☐ and number of days between onset of seizure and death ☐☐☐

39. Was the patient booked for an EEG following discharge? Yes ☐ No ☐ **If yes** please specify date ☐☐/☐☐/☐☐

40. Does the patient have an ongoing seizure disorder? Yes ☐ No ☐ Unsure ☐

41. Was the patient on anticonvulsant medication on discharge? Yes ☐ No ☐ Unsure ☐

If yes, please specify _____

42. Additional comments _____

_____

_____

43. ICD-10-AM diagnosis codes _____

_____