FETAL ALCOHOL SPECTRUM DISORDER (FASD)

Australian Paediatric Surveillance Unit

If you have any questions about this form please contact the APSU (02) 9845 3005 or email: SCHN-APSU@health.nsw.gov.au

APSU Office Use Only	
Study ID #:	
Month/Year Report:	
Version 2.1: 13.11.2018	

Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided.
DK=Don't Know; NA = Not Applicable

REPORTING CLINICIAN'S DETAILS **1.** APSU Dr Code/Name: __ __ __ __ /_____ **2**. Date questionnaire completed: __ __ /__ __ /__ __ __ __

PATIENT DETAILS

3. First 2 letters of first name: __ __ **4.** First 2 letters of surname: __ __ **5.** Date of Birth: __ __ / __ __ / __ __ __ __

6. Sex: ☐ Male ☐ Female **7.** Postcode of family: __ __ __ __ **8.** Date of diagnosis: __ __ / __ __ / __ __ __ __

9. Racial Background *(select all that apply)*: ☐ Aboriginal ☐ Caucasian ☐ Pacific Islander ☐ Torres Strait Islander ☐ African ☐ Asian ☐ DK ☐ Other *(specify):*_____

10. Did you make the FASD diagnosis? ☐ Yes ***(please go to Q11)*** ☐ No – if this patient is primarily cared for by another physician who you believe could provide additional details, please write their name below and return this form to the APSU. If no other report is received for this child we will contact you for further information. Physician's Name:_____ Clinic/hospital: _____

BIOLOGICAL MOTHER'S DETAILS

11. Mother's age at the time of child's birth: __ __ (years) **or** ☐ DK

12. Mother's country of birth: ☐ Australia ☐Other *(specify):*_____ **13.** Mother's racial background: ☐ Caucasian ☐ Aboriginal ☐ Pacific Islander ☐ Torres Strait Islander ☐ African ☐ Asian ☐DK ☐ Other *(specify):* _____

PATIENT'S FAMILY CHARACTERISTICS

14. Who is the child's primary carer? ☐ biological parents ☐ grandparent/s ☐ foster carer/s ☐ adoptive parent/s ☐ Other *(specify)*: _____

15. Has the child ever been or previously been under the care of community or child protection services? ☐ Yes ☐ No ☐ DK

15a. If yes, specify: _____

16. Have any of the child's siblings been diagnosed with FASD? ☐ No ☐ No siblings ☐ Yes *(specify)*: _____

FASD DIAGNOSIS

17. Who first suspected this child may have a FASD? ☐ I did ☐ parent/caregiver ☐ teacher ☐ GP ☐ Other *(specify)*: _____

18. What is the child's FASD diagnosis? ☐ FASD with 3 Sentinel Facial Features ☐ FASD with *less than* 3 Sentinel Facial Features ☐ Other *(specify* _____

19. Was the diagnosis made by:
☐ paediatrician or other medical practitioner in a multidisciplinary or interdisciplinary team
☐ paediatrician or other medical practitioner, based on reports from one or more health professionals
☐ paediatrician or other medical practitioner, on their own
☐ Other (*specify):* _____

20. Did the diagnostic process include assessments by any of the following health professionals?
☐ clinical geneticist ☐ psychologist/neuropsychologist ☐ occupational therapist ☐ speech pathologist ☐ physiotherapist
☐ child/adolscent psychiatrist ☐ Other *(specify):*_____

GROWTH

21. Please specify birth measurements: **(i)** Gestational age: _____ (Wks) ☐ DK **(ii)** Head Circumference: _____ (cm) ___ (%ile) ☐ DK
(iii) Birth Weight: _____ (kg) _____ (%ile) ☐ DK **(iv)** Birth Length: _____ (cm) ___ (%ile) ☐ DK

22. Has the child had unexplained deficit in height or weight (≤10th percentile) at any time after birth? ☐ Yes ☐ No ☐ DK

If Yes, please specify: Age _____ (years) _____ (months) Weight: _____ (kg) _____ (%ile) ☐ DK Height:_____(cm) _____ (%ile) ☐ DK

23. Which growth charts were used? ☐ CDC Growth Charts ☐ WHO Child Growth Standards ☐ None ☐ DK ☐ Other: _____

DIAGNOSTIC CRITERIA – FASD facial features

24. Were any of the following characteristic FASD facial features identified?

(i) short palpebral fissures (2 SD or more below the mean)	☐ Yes	☐ No	☐ DK	☐ not assessed
(ii) smooth philtrum (philtrum rank 4 or 5 on Lip-Philtrum Guide UW guidelines)	☐ Yes	☐ No	☐ DK	☐ not assessed
(iii) thin upper lip (lip rank 4 or 5 on Lip-Philtrum Guide UW guidelines)	☐ Yes	☐ No	☐ DK	☐ not assessed

25. How were the characteristic FASD facial features assessed *(tick all that apply)*? ☐ visual examination for facial phenotype (gestalt method) ☐ direct measurement palpebral fissure (ruler) ☐ ranking lip-philtrum guide ☐ facial photographic analysis ☐ not assessed

26. Which University of Washington Lip-Philtrum Guide was used? ☐ Caucasian ☐ African American ☐ None

26a. Which palpebral fissure charts were used? ☐ Stromland ☐ Claren ☐ Iosub ☐ Hall ☐ Other *(please specify):* _____

DIAGNOSTIC CRITERIA

27. Was the child's head circumference ≤3rd percentile at any time? **i)** ☐ No ☐ DK ☐ Yes **ii)** Age when first noted? _____

28. Was CNS imaging performed? ☐ No ☐ Yes; ***If yes, which tests*** (eg. CT, MRI, PET) _____

29. Was a clinically significant structural CNS abnormality detected? ☐ No ☐ Yes *(specify):* _____

30. If child is < 6 years of age was there global developmental delay? ☐ Yes ☐ No ☐ DK

30a. If yes, what age was this diagnosed? _____ (years) _____ (months) ☐ DK

31. Was there evidence of clinically significant neurological CNS abnormality otherwise unexplained? ☐ Yes ☐ No ☐ DK

If yes: ☐ seizure disorder ☐ cerebral palsy ☐ visual impairment ☐ sensorineural hearing loss ☐ other *(specify):* _____

32. Was CNS function assessed? ☐ Yes ***(Complete table below)*** ☐ No ***(please go to Q33)***

Which domains were assessed ***(please tick all that apply)***	**Severe Impairment Yes/No/DK**	**How were impairments assessed? *(please tick all that apply)***			
		Caregiver report	Clinical evaluation /observation	Standardised, validated or psychometric testing	Specify other test used
☐ Motor skills		☐	☐	☐	☐
☐ Cognition		☐	☐	☐	☐
☐ Language		☐	☐	☐	☐
☐ Academic achievement		☐	☐	☐	☐
☐ Memory		☐	☐	☐	☐
☐ Attention		☐	☐	☐	☐
☐ Executive functioning, including impulse control and hyperactivity		☐	☐	☐	☐
☐ Affect regulation		☐	☐	☐	☐
☐ Adaptive behaviour, social skills or social communication		☐	☐	☐	☐

33. Has the child been diagnosed with ADHD? ☐ Yes ☐ No ☐ DK

34. Does the child have a hearing impairment? ☐ No ☐ DK ☐ Not tested ☐ Yes *(specify)*:_____

35. Does the child have a vision impairment? ☐ No ☐ DK ☐ Not tested ☐ Yes *(specify)*:_____

DIAGNOSTIC CRITERIA – prenatal alcohol exposure and exposure to other substances

36. Was prenatal alcohol exposure: ☐ confirmed present ☐ unknown ***(please go to Q39)*** ☐ confirmed absent

37. Was a standard tool used to assess prenatal alcohol exposure: ☐ No ☐ Yes; ***specify which tool (e.g. AUDIT-C):***_____

37a. If the AUDIT-C was used, what was the score? _____

38. What was the main source of information about prenatal alcohol exposure? ☐ biological mother ☐ direct witness
☐ offical records (e.g. medical, legal) ☐ Other *(specify)*: _____

39. At any time during pregnancy, was alcohol consumption reported at the following levels:
(i) 7 or more standard drinks per week: ☐ Yes ☐ No ☐ DK **(ii)** 5 or more standard drinks on any occasion: ☐ Yes ☐ No ☐ DK

40. Does the biological mother have a history of: **(i)** alcohol use disorder (including dependency): ☐ Yes ☐ No ☐ DK
(ii) alcohol-related health problems/injury: ☐ Yes ☐ No ☐ DK

41. Was there prenatal exposure to other substances? **(i)** Cigarettes: ☐ Yes ☐ No ☐ DK **(ii)** Marijuana: ☐ Yes ☐ No ☐ DK
(iii) Heroin: ☐ Yes ☐ No ☐ DK **(iv)** Amphetamines: ☐ Yes ☐ No ☐ DK **(v)** Cocaine: ☐ Yes ☐ No ☐ DK
(vi) Phenytoin or Valproate: ☐ Yes (*specify):*_____ ☐ No ☐ DK **(vii)** Other *(specify):*_____

OTHER CONDITIONS

42. Does the child have any other congenital anomalies? ☐No ☐ DK ☐ Yes *(specify):*_____

43. Does the child have any behavioural/psychiatric conditions?
(i) Conduct disorder: ☐ Yes ☐ No ☐DK **(ii)** Anxiety: ☐ Yes ☐ No ☐DK **(iii)** Oppositional defiant disorder ☐ Yes ☐ No ☐ DK
(iv) Intermittent Explosive Disoder: ☐ Yes ☐ No ☐ DK **(v)** Depression: ☐ Yes ☐ No ☐ DK **(vi)** Sleeping disorder: ☐ Yes ☐ No ☐ DK
(vii) Other *(specify):* _____

44. Does the child have any of the following dysmorphisms?
(i) clinodactyly? ☐ Yes ☐ No ☐ DK **(ii)** camptodactyly? ☐ Yes ☐ No ☐ DK
(iii)'railroad-track' ear (helix crus horizontal)? ☐ Yes ☐ No ☐ DK **(iv)** epicanthic folds? ☐ Yes ☐ No ☐ DK
(v)'hockey stick' palmar creases? ☐ Yes ☐ No ☐ DK **(vi)** Other *(specify):* _____

45. Has the child had: Chromosomal microarray analysis; ☐ No ☐ DK ☐ Yes; ***Results***:_____
Karyotype testing: ☐ No ☐ DK ☐ Yes; ***Results:*** _____

46. Have the following conditions been excluded: **(i)** fragile X syndrome ☐ Yes ☐ No ☐DK **(ii)** fetal anticonvulsant syndromes (Dilantin/Valproate) ☐ Yes ☐ No ☐ DK **(iii)** chromosome microdeletions syndromes (e.g. Williams syndrome) ☐ Yes ☐ No ☐ DK

MANAGEMENT

47. Which services are currently being accessed by this child?
☐ general or developmental paediatrics ☐ occupational therapy ☐ psychology ☐ speech pathology
☐ physiotherapy ☐ early childhood intervention ☐ educational support ☐ social work
☐ child protection services ☐ Other *(specify)*:_____

48. Are these services adequate to manage this child's needs? ☐ Yes ☐ No ☐ DK
If No, *(specify):*_____

49. Has information on this child's FASD diagnosis been provided to any third parties (e.g. other health professionals, teacher, lawyer, community services)? ☐ No ☐ DK ☐ Yes *(specify):*_____

50. Has the family been told about the National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD)? ☐ Yes ☐ No ☐ DK

Thank you for your help with this research project.
Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au or fax to 02 9845 3082
or mail to Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145 - even if you don't complete all items.

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Sydney Medical School, The University of Sydney.
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