

Microcephaly in children < 12months old

APSU Office Use Only

Australian Paediatric Surveillance Unit

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

Study ID #:

Month/Year Report:

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*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; OFC = Occipito-Frontal Circumference***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. Racial Background (select all that apply): Aboriginal Caucasian Pacific Islander Torres Strait Islander African Asian DK Other (specify): _____9. Country of birth of the child: Australia Other (specify): _____10. Did you make the diagnosis of microcephaly? 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: _____**PARENTS' DETAILS**11. Mother's age at the time of child's birth: ___ (years) or DK12. 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): _____14. Father's country of birth: Australia Other (specify): _____ 15. Father's racial background: Caucasian Aboriginal Pacific Islander Torres Strait Islander African Asian DK Other (specify): _____**CLINICAL FEATURES**16. Date of microcephaly diagnosis: antenatally (specify): _____ (wks) at birth other date: ___/___/_____17. Was the child born at: full term premature DK (i). If premature, please provide gestational age _____ (weeks)18. Please specify the following measurements **at birth**:(i) Occipito-Frontal Head Circumference (OFC): _____ (cm) _____ (%ile) DK(ii) Birth Weight: _____ (kg) _____ (%ile) DK (iii) Birth Length: _____ (cm) _____ (%ile) DK19. If microcephaly was diagnosed **after birth** and **before 12 months of age** please provide:(i) Date when OFC measured: ___/___/___ DK (ii) (OFC): _____ (cm) _____ (%ile) DK20. Which growth charts/calculators were used for OFC measurements? Integrowth Charts CDC Growth Charts WHO Child Growth Standards None DK Other: _____21. Has the child had unexplained deficit in length or weight ($\leq 10^{\text{th}}$ percentile) at any time after birth? Yes No DK*If Yes, please specify:* (i) Age _____ (months) (ii) Weight: _____ (kg) _____ (%ile) DK (iii) Height: _____ (cm) _____ (%ile) DK22. Does the child have any other congenital anomalies? No DK Yes (specify): _____**PREGNANCY & FAMILY HISTORY**23. Did the mother have antenatal screening for: Rubella Varicella Syphilis HIV Toxoplasmosis Cytomegalovirus HSV Other (specify): _____24. (i) *If Yes*, were any of these test positive? Yes No DK (ii) *If Yes*, which ones? Rubella Varicella Syphilis HIV Toxoplasmosis Cytomegalovirus HSV Other (specify): _____Is there a history during pregnancy for this child of: 25. Maternal phenylketonuria? Yes No DK26. Poorly controlled maternal diabetes? Yes No DK 27. Pre-eclampsia placental insufficiency? Yes No DK28. Exposure to alcohol in pregnancy? Yes No DK*If yes*, 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 one occasion: Yes No DK29. Is there a history of exposure to drugs (illicit, prescribed or over the counter) in pregnancy? Yes No DK *If yes*, which drugs?(i) Cigarettes: Yes No DK (iv) Amphetamines: Yes No DK(ii) Marijuana: Yes No DK (v) Cocaine: Yes No DK(iii) Heroin: Yes No DK (vi) Phenytoin or Valproate: Yes (specify): _____ No DK(vii) Other drugs Yes (specify): _____ No DK30. Severe deprivation including malnutrition in the mother during pregnancy? Yes No DK31. Were there any other complications during pregnancy for this child? Yes No DK *If Yes*, specify: _____32. Were there any complications during previous pregnancies? No previous pregnancies Miscarriage Stillbirth Other (specify): _____ DK

33. Has a sibling of this child been diagnosed with microcephaly? No siblings Yes No DK

34. Is there a history of congenital abnormalities or genetic disorders in this family? Yes No DK **If yes, please specify:** _____

FEATURES & INVESTIGATIONS FOR THE INFANT

35. Has the child had: (i) Chromosomal microarray analysis No DK Yes; **Results:** _____

(ii) Karyotype testing: No DK Yes; **Results:** _____

36. Are there any signs or symptoms of clinically significant neurological/CNS abnormality? Yes No DK **If yes, which?:**

seizure disorder abnormal reflexes muscle spasticity joint contracture flaccidity/floppiness lethargy apnoea

irritability Other neurological abnormality (specify): _____

37. Was CNS imaging performed? No DK Yes; **If yes, which?** CT MRI US Other (specify): _____

38. Was a clinically significant structural CNS abnormality detected? No DK Yes (specify): _____

39. Is there evidence of severe CNS trauma, ischaemic or haemorrhagic stroke prenatally or in the neonatal period? Yes No DK

40. Is there evidence of severe deprivation including malnutrition in the infant? Yes No DK

41. Has this child been tested for any of the following congenital infections? Rubella Varicella Syphilis HIV

Toxoplasmosis Cytomegalovirus HSV Zika Other (specify): _____

42. **If Yes**, were any of these tests positive? Yes No DK **(ii). If Yes, which ones?** Rubella Varicella Syphilis HIV

Toxoplasmosis Cytomegalovirus HSV Zika Other (specify): _____

TRAVEL HISTORY FOR MOTHER & PARTNER

43. Did the mother or her sexual partner travel outside Australia during pregnancy or in the 3 months before pregnancy?

	Travelled outside Australia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	If yes:	
		To which countries? (please list all)	When? (dates if possible)
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		
Partner (3 months before & during pregnancy)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		

44. Did the mother or partner have any illness during or since returning from travels? Yes No DK **If yes, which symptoms?**

	Fever	Rash	Conjunctivitis	Myalgia	Headache	Arthralgia/Arthritis	Other (specify):
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45. Was Zika virus infection ever considered as a possible cause of microcephaly in this child? Yes No DK

46.(i) If yes, was the infant tested for evidence of past/current Zika virus infection? Yes No DK **If Yes, result:** _____

(ii) If yes, was the mother tested for evidence of past/current Zika virus infection? Yes No DK **If Yes, result:** _____

(iii) If yes, has the mother's sexual partner (3 months before pregnancy and during pregnancy) been tested for evidence of past/current Zika virus infection? Yes No DK **If Yes, result:** _____

(iv) Has the child been reported to a public health unit? Yes No DK **If Yes, which unit?** _____

INFANT OUTCOMES (Developmental Milestones)

47. Is the child still alive? Yes No **If No**, date of death ___/___/___ **If NO, please got to Q52**

48. Has the child reached all developmental milestones for their age? Yes No DK **If no**, which milestones are delayed (e.g. Fine/Gross motor, growth retardation, intellectual disability)? _____

49. Does the child have cerebral palsy? Yes No DK

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

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

CAUSES OF MICROCEPHALY

52. What are the most likely reasons for the microcephaly in this child? (please tick all that apply)

<input type="checkbox"/> Chromosomal syndrome (specify):	<input type="checkbox"/> Maternal phenylketonuria
<input type="checkbox"/> Single gene defects (specify):	<input type="checkbox"/> Poorly controlled maternal diabetes
<input type="checkbox"/> Neural tube defects (specify):	<input type="checkbox"/> Severe CNS trauma, ischaemic or haemorrhagic stroke
<input type="checkbox"/> Exposure to teratogens in pregnancy (e.g. alcohol, drugs and other toxins)	<input type="checkbox"/> Severe deprivation including malnutrition, or placental insufficiency
<input type="checkbox"/> Congenital or neonatal infection (specify): <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> Rubella <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> HSV <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV <input type="checkbox"/> Varicella <input type="checkbox"/> Zika virus <input type="checkbox"/> Other infection (specify):	
<input type="checkbox"/> Cause currently unknown	

53. If the cause is known/suspected, has this been confirmed (e.g. by laboratory testing, imaging, genetic testing)? Yes No DK