Chronic Fatigue Syndrome (CFS)
Australian Paediatric Surveillance Unit
Please contact the APSU (02) 9845 3005; apsu@chw.edu.au if you have any questions about this form.

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

REPORTING CLINICIAN'S DETAILS **1**. APSU Dr Code/Name: ☐☐☐☐/_____ **2.** Month/Year of Report: ☐☐/☐☐

3. Date questionnaire completed: ☐☐/☐☐/☐☐☐☐

PATIENT DETAILS **4.** First 2 letters of first name:☐☐ **5.** First 2 letters of surname: ☐☐ **6.** Date of Birth: ☐☐/☐☐/☐☐

7. Sex: ☐ M ☐ F **8.** Postcode of family: ☐☐☐☐ **10.** Child's ethnicity: ☐ Caucasian ☐ Asian ☐ African or Middle Eastern ☐ Other (*please specify*) _____ ☐ DK

If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to the APSU. Please keep the patient's name and other details in your records. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

The primary clinician caring for this child / young person is: ***Name:*** ***Hospital:***

DIAGNOSIS **11**. What was the duration of symptoms prior to diagnosis?

☐ <3 months ☐ 3 - 6 months ☐ 7 - 12 months ☐ 13 - 24 months ☐ >24 months

12. Was the onset of symptoms? ☐ Sudden (i.e., < 1 week) ☐ Gradual (i.e., > 1 week) ☐ Unknown

13. What was the trigger for onset? ☐ Infectious *(please specify)*_____ ☐ Severe stress *(please specify)*_____

☐ Other *(please specify)* _____ ☐ Unknown

14. Which of the following symptoms did the child/young person have? *(please tick all that apply)*

☐ Fatigue
☐ Light-headedness/ Dizziness
☐ Post-exertional malaise
☐ Cardiovascular: Orthostatic intolerance/neurally mediated hypotension/palpitations with or without cardiac arrhythmias
☐ Sleep disturbance/unrefreshing sleep
☐ Respiratory symptoms (e.g. laboured breathing)
☐ Pain (☐ musculoskeletal, ☐ abdominal, ☐ chest, ☐ joint)
☐ Loss of thermostatic stability/intolerance of extreme temperatures
☐ Headache
☐ Marked weight change
☐ Attention/concentration difficulties
☐ Flu-like symptoms (e.g. sore throat, tender lymph nodes, general malaise)
☐ Difficulty processing information
☐ Susceptibility to viral infections with prolonged recovery periods
☐ Short-term memory loss
☐ New sensitivities to food, medications, odours and/or chemicals
☐ Perceptual/sensory disturbance (e.g., inability to focus vision, impaired depth perception)
☐ Gastro-intestinal (e.g. nausea, bloating, abdominal pain)
☐ Hypersensitivity to noise or light
☐ Genitourinary (e.g. urinary urgency or frequency, nocturia)
☐ Motor: Muscle weakness, twitching, poor motor coordination
☐ Other (*please specify*) _____

15. How would you rate the severity of the condition?

☐ Mild (generally able to attend school on a full-time basis) ☐ Moderate (missing the equivalent of 1 - 4 days of school per week)
☐ Severe (housebound, not able to attend school) ☐ Very Severe (mostly bedbound, needs assistance with personal care)

16. Did the child/young person have a concurrent diagnosed psychiatric condition? *(please tick all that apply)*

☐ Somatisation ☐ Eating disorder ☐ Depression ☐ School phobia ☐ Anxiety ☐ Other *(please specify)*_____

17. Did the child/young person have a concurrent diagnosed medical condition? *(please tick all that apply)*

☐ Migraine ☐ Irritable Bowel Syndrome or Function Bowel Disorder ☐ Multiple food or chemical sensitivites/food intolerance

☐ Fibromyalgia or chronic widespread pain ☐ Dysmenorrhoea ☐ Postural orthostatic tachycardia syndrome (POTS)

☐ Joint hypermobility ☐ Other *(please specify)* _____

18. Is there a family history of the following conditions?

Condition	**Maternal**	**Paternal**
CFS	☐ Yes ☐ No ☐ DK	☐ Yes ☐ No ☐ DK
Chronic Pain	☐ Yes ☐ No ☐ DK	☐ Yes ☐ No ☐ DK
Arthritis/Connective tissue disorder	☐ Yes ☐ No ☐ DK	☐ Yes ☐ No ☐ DK
Fibromyalgia	☐ Yes ☐ No ☐ DK	☐ Yes ☐ No ☐ DK
Depression	☐ Yes ☐ No ☐ DK	☐ Yes ☐ No ☐ DK
Anxiety disorder	☐ Yes ☐ No ☐ DK	☐ Yes ☐ No ☐ DK

Please list any other relevant medically diagnosed family history: _____

19. Which of the following investigations were completed in order to make the diagnosis of CFS? *(Please tick all that apply)*

Investigation/Test	***Test Results**** *(please tick which applies)*			***Investigation/Test***	***Test Results**** *(please tick which applies)*		
	Abnormal	***Normal***	***DK***		***Abnormal***	***Normal***	***DK***
☐ *None*	*n/a*	*n/a*	*n/a*	☐ *Serum Vitamin D*			
☐ *Full blood count and differential*				☐ *Serum phosphate*			
☐ *Erythrocyte sedimentation rate (ESR)*				☐ *Serum magnesium*			
☐ *C-reactive protein (CRP)*				☐ *Serum calcium*			
☐ *Urea, electrolytes & creatinine (UEC test)*				☐ *Serum Creatine Kinase*			
☐ *Antinuclear Antibody (ANA test)*				☐ *Cortisol*			
☐ *Blood glucose*				☐ *Ferriten*			
☐ *Brain scan (e.g., MRI, CT)*				☐ *Rheumatoid Factor*			
☐ *Liver function tests*				☐ *Hair Analysis*			
☐ *Thryoid function test*				☐ *Tests for Lyme Disease*			
☐ *Allergy tests*				☐ *Tests for Ross River virus*			
☐ *Stool tests*				☐ *Tests for Barmah Forest virus*			
☐ *Coeliac screen*				☐ *Tests for Q fever*			
☐ *Protein electrophoresis screen*				☐ *Tests for parvovirus (B19)*			
☐ *CMV serology*				☐ *Other (specify)*			
☐ *EBV serology*							

**** According to laboratory reference values***

20. Has the patient utilised any of the following services? *(Please tick all that apply)*

☐ Pain medicine ☐ Psychiatry ☐ Occupational therapy ☐ Sleep Specialist

☐ Rheumatology ☐ Psychology ☐ Rehabilitation medicine ☐ Specialist CFS/ME Service

☐ Adolescent medicine ☐ Infectious diseases ☐ Teacher/School ☐ Dietitian

☐ Neurology ☐ Physiotherapy ☐ Other *(please specify)*_____

☐ Alternative Therapist (e.g. Chiropractor, homeopath), *please specify*_____

21. Did you recommend any of the following treatment strategies? *(Please tick all that apply)*

Diet changes/nutritional advice *(i.e. healthy eating, diet restrictions)*	☐ Yes ☐ No	Graded exercise therapy	☐ Yes ☐ No
Sleep hygiene *(i.e. bedtime routines, set sleep/wake times)*	☐ Yes ☐ No	Cognitive Behavioural Therapy	☐ Yes ☐ No
Symptom management with medication *(e.g. pain)*	☐ Yes ☐ No	Bed Rest	☐ Yes ☐ No
Modified school program or home tutoring	☐ Yes ☐ No	None of the above	☐ Yes ☐ No
Pacing *(i.e. balancing activity with rest)*	☐ Yes ☐ No	Other *(Specify)*	☐ Yes ☐ No

Thank you for your help with this research project. Please return this questionnaire to the APSU in the reply-paid envelope or fax to 02 9845 3082. Australian Paediatric Surveillance Unit, Kid's Research Institute, Locked Bag 4001, Westmead NSW 2145. The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Sydney Medical School, The University of Sydney. APSU is funded by the Australian Government Department of Health and Ageing. This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.