Acute Rheumatic Fever (ARF) Questionnaire
Australian Paediatric Surveillance Unit

Please ring Ms Sara Noonan on (08) 8263-7801 if you wish to discuss this questionnaire

REPORTING CLINICIANS

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.** Post code of family: ☐☐☐☐ **9.** Child's country of birth: _____

10. Usual place of residence: ☐Inner-city ☐City Suburb ☐Large town ☐Small town/community ☐Remote area

11. Child's Ethnicity: ☐ATSI ☐Caucasian ☐Asian ☐Pacific Islander ☐Middle Eastern ☐African ☐Other _____

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 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 is:

Name: ***Hospital:***

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

Family details and relevant history

12. Mother's country of birth: _____ ☐DK **13.** Father's country of birth: _____ ☐DK

14. Number of other children in the family (siblings): ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐>5 ☐DK

15. Number of siblings ever diagnosed with ARF: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐>5 ☐DK

16. How many bedrooms are there in the child's dwelling? ☐1 ☐2 ☐3 ☐4 ☐>4 ☐DK

17. How many people usually sleep in the child's dwelling? ☐1-4 ☐5-9 ☐>9 ☐DK

18. How many of these people are children aged <15yrs ☐1-4 ☐5-9 ☐>9 ☐DK

19. Does the child have a primary health provider? ☐Yes ☐No ☐DK

If yes: 19a. Who is the child's usual primary health provider? ☐GP ☐Local hospital ☐Aboriginal Health Worker ☐Flying Doctor ☐Other, *specify*:_____

Acute Rheumatic Fever (ARF) diagnosis

20. Date of diagnosis for current ARF episode: ☐☐/☐☐/☐☐

21. Has this child been previously diagnosed with ARF? ☐Yes ☐No ☐DK

21a. Please provide months/years for previous diagnoses: ☐☐/☐☐ ☐☐/☐☐ ☐☐/☐☐

22. Please select all diagnostic criteria present in the current episode of ARF?

MAJOR criteria: ☐Carditis ☐Polyarthritis ☐Sydenham's Chorea
☐Erythema marginatum ☐Subcutaneous nodules
☐Polyarthralgia *(high risk groups)* ☐Aseptic mono-arthritis *(high risk groups)*

MINOR criteria: ☐Fever (*highest temp*_____ ^{o}C) ☐ESR ≥30mm/hr (*highest ESR*_____*mm/hr*)
☐Prolonged PR interval ☐CRP ≥30mg/L (*highest CRP*_____*mg/L)*
☐Aseptic mono-arthritis *(low risk groups)* ☐Polyarthralgia *(low risk groups)*

23. If any of the arthritic features were present, which joints were involved? *(tick all that apply)*
☐Wrist(s) ☐Ankle(s) ☐Knee(s) ☐Elbow(s)
☐Other joints. (*Please Specify*): _____

24. Were any cardiac valve lesions present? ☐Yes ☐No ☐DK ***If No, please go to question 27.***

If yes: *(tick all that apply)*

24a. ☐Mitral valve regurgitation: *Severity:* ☐None ☐Mild ☐Moderate ☐Severe ☐DK

24b. ☐Mitral stenosis ☐DK

24c. ☐Aortic valve regurgitation: *Severity:* ☐None ☐Mild ☐Moderate ☐Severe ☐DK

24d. ☐Aortic stenosis ☐DK

24e. ☐Tricuspid valve lesion (*specify*) _____ ☐DK

24f. ☐Pulmonary valve lesion (*specify*) _____ ☐DK

25. Evidence of valve lesions is based on ☐Echocardiogram ☐Clinical Assessment

If echocardiogram, please de-identify and attach the echocardiogram report to this questionnaire if available.

26. Is the echocardiogram report attached? ☐Yes ☐No ☐*NA*

27. Was there evidence of heart failure? ☐Yes ☐No ☐DK

28. Was there a sore throat (within 3 weeks of ARF symptoms)? ☐Yes ☐No ☐DK

If yes: ***28a.*** Was medical attention sought for the sore throat? ☐Yes ☐No ☐DK

29. Was there evidence of skin sores (within 3 weeks of ARF symptoms)? ☐Yes ☐No ☐DK

30. Was there evidence of Group A streptococcal (GAS) infection? ☐Yes ☐No ☐DK

If yes, please provide the following details:

☐Culture: ☐Yes ☐No ☐DK ***If yes,*** identify site (throat, skin, other) _____

☐ASOT titre Result_____ Date ☐☐/☐☐/☐☐

☐Anti DNase titre Result_____ Date ☐☐/☐☐/☐☐

31. Were antibiotics given within the 3 weeks prior to onset of ARF symptoms? ☐Yes ☐No ☐DK

If yes, ***31a.*** Which antibiotic was used? _____ ☐DK

ARF management and outcome

32. Which treatments were given during the acute phase of this episode of ARF? *(tick all that apply)*

☐No treatment given ☐Prednisolone ☐Carbamazepine

☐Paracetamol ☐Frusemide ☐Valproic acid

☐Aspirin ☐Digoxin ☐Penicillin

☐Codeine ☐Other *(specify):*_____

33. Was bed rest recommended? ☐Yes ☐No ☐DK

If Yes: 33a. How many days of bed rest did the child have? _____

34. Was secondary prophylaxis initiated following this diagnosis? ☐Yes ☐No ☐DK

35. Which secondary prophylaxis regimen(s) was prescribed following this episode of ARF?

☐Benzathine penicillin G (3-weekly) ☐Penicillin V 250mg (bd)

☐Benzathine penicillin G (4-weekly) ☐Erythromycin 250mg (bd) ☐DK

☐Benzathine penicillin G (every calendar month)

36. If this is an ARF recurrence, what do you believe is the primary cause?

☐Secondary prophylaxis was not given, *due to:* _____

☐Secondary prophylaxis given but failed, *due to:* _____

☐Other reason (*specify*): _____ ☐DK

37. Was cardiac surgery recommended? ☐Yes ☐No ☐DK

If No or DK, go to question 38

If yes: ***37a.*** If yes, has surgery been performed? ☐Yes ☐No ☐Awaiting surgery ☐DK

37b. If yes, describe procedure: _____

37c. Date of surgery:___/___/_____ ***37d.*** Name of surgical unit/hospital: _____

Barriers to diagnosis

38. Did you encounter any barriers to making the diagnosis of ARF for this episode in this child? ☐Yes ☐No ☐DK

If Yes, please answer 39 and 40. If No, Thank you, this is the end of the questionnaire

39. Delayed presentation to a health professional? ☐Yes ☐No ☐DK

If yes*: *39a. Time between onset of symptoms and presentation to health professional_____ days.

39b. Describe reasons for delayed presentation: eg. (Lack of access to primary health services):

_____

_____

40. Delayed referral following initial presentation? ☐Yes ☐No ☐DK

If yes: ***40a.*** Time from initial presentation _____days **or** _____ weeks

40b. Describe reasons for delayed referral / other barriers to diagnosis? (eg. difficulty with ARF diagnosis – unclear presentation; lack of staff skills)_____

_____

Please return this questionnaire in the addressed reply-paid envelope to
Ms Sara Noonan C/- 8 Denham Drive VALLEY VIEW SA 5093

Thank you for your assistance with this study, which has been approved by a Human Research Ethics Committee. The APSU is a Unit of the Royal Australasian College of Physicians (Division of Paediatrics and Child Health) and is funded by the NHMRC (Enabling Grant No. 40284), the Department of Health and Ageing, and the Faculty of Medicine at the University of Sydney.