ADVERSE EVENTS ASSOCIATED WITH THE USE OF 
COMPLEMENTARY OR ALTERNATIVE MEDICINE (CAM) QUESTIONNAIRE 
Australian Paediatric Surveillance Unit

Please keep a record of the child's details in your APSU folder. Please ring our office on 03 9345 6987 if you have any problems completing this form. Thank you for your time.

REPORTING CLINICIAN
1. APSU Dr Code/Name                     2. Month/Year of Report

PATIENT
3. First 2 letters of first name         4. First 2 letters of surname
5. Date of Birth                          6. Sex M F
7. Postal code                            
8a. Weight in kg                          8b. Height in cm
9a. Country of birth: Child………………….Father:……………………Mother:……………………
9b. Country of Origin: Father:………………..….Mother:……………………
(eg father was born in Australia but the ancestral line originated from China, then the country of origin is China)

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.

DETAILS OF ADVERSE EVENT DUE TO USE OF COMPLEMENTARY OR ALTERNATIVE MEDICINE
10. Description of event (date of reaction, clinical features, significant biochemical changes and other abnormalities, time of onset of adverse event in relation to CAM and other details): 

11. Did the adverse event lead to hospitalisation? Yes No If yes, duration ………..(days)
12. Did the patient require admission to ICU? Yes No If yes, duration ………..(days)
13. Did the adverse event require treatment with conventional/prescribed medications/therapy? Yes No If yes, please specify………………………………………………………………………
14. Severity (please tick the maximum effect of the event on the patient) 

☐ Mild  an adverse experience which is easily tolerated by the patient, causing minimal discomfort and not interfering with everyday activities (e.g. a minor rash).

☐ Moderate  an adverse experience which is sufficiently discomforting to interfere with normal everyday activities (e.g. nausea & vomiting requiring time away from school).

☐ Severe  an adverse experience which is incapacitating and prevents normal everyday activities and/or requires therapeutic intervention (e.g. use of a prescription drug or hospitalisation).

☐ Life threatening  the patient was perceived to be at risk of death from the event as it occurred (e.g. an anaphylactic reaction).

☐ Fatal  The patient died
15. Type of Complementary or Alternative Medicine involved:

- [ ] Naturopathy
- [ ] Kinesiology
- [ ] Colour Therapy
- [ ] Herbal Therapy
- [ ] Chiropractic
- [ ] Hypnotherapy
- [ ] Traditional Chinese Medicine
- [ ] Osteopathy
- [ ] Reiki
- [ ] Homeopathy
- [ ] Therapeutic Massage
- [ ] Unknown
- [ ] Acupuncture
- [ ] Moxibustion
- [ ] Alexander Technique
- [ ] Acupressure
- [ ] Reflexology
- [ ] Ayurveda
- [ ] Aromatherapy
- [ ] Therapeutic Touch
- [ ] Yoga
- Other, please specify: ....................................................................................................................

16. What condition was the therapy being used for? ............................................................................

17. Who prescribed / initiated the therapy? ...........................................................................................

18. Pattern of use. Duration:  
   - [ ] days
   - [ ] weeks
   - [ ] months

   Frequency  
   - [ ] daily
   - [ ] weekly
   - [ ] monthly
   - [ ] less than monthly

FOR ADMINISTERED SUBSTANCES

19. Brand name........................................  Manufacturer........................................

20. Were the constituents of administered substances included on the label? Yes [ ] No [ ]
   If yes, please specify content........................................................................................................

21. Were the administration details stated on the label? Yes [ ]  No [ ]
   If yes, please specify: ....................................................................................................................

22. Was there a use by date on the label? No [ ] Yes [ ]  Use by date [ ]/ [ ]/ [ ]

DEGREE OF ASSOCIATION

23. Please rate your assessment of the relationship between the adverse event
   and the use of the Complementary or Alternative Medicine:
   - [ ] Not assessable
   - [ ] unrelated
   - [ ] probably related
   - [ ] probably unrelated
   - [ ] definitely related.

24. During the period of administration of the Complementary or Alternative Medicine, was the child also
   receiving any other therapy or treatment (include any drug names, dose, route)?  
   .................................................................................................................................

25. Is it possible that the adverse event was related to the conventional medication/ therapy?
   .................................................................................................................................

26. Do you believe that the patient was harmed by a failure to use conventional medication/ therapy?
   .................................................................................................................................

Please return this questionnaire in the addressed reply-paid envelope.

Thank you for your help with this project.