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 (eg 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 (eg 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.