

Subcute Sclerosing Panencephalitis Questionnaire
Australian Paediatric Surveillance Unit

PAEDIATRICIAN

1. Dr Code /.....2. Report Code /
3. Name
4. Address
5. Telephone6. Fax

PATIENT DATA

7. First 2 letters of surname
8. First 2 letters of first name
9. Date of Birth / /
10. Birth order: First Second Third Fourth or subsequent child in family
11. Sex M F
12. Postcode
13. Ethnic origin of mother Caucasian Asian Aboriginal Other (please specify)
14. Country of Birth

HISTORY

15. Previous history of measles Yes No Don't Know
16. If yes, was the diagnosis made on clinical grounds Yes No Don't Know
17. Age at measles illness (year / month) /
18. Previous history of measles immunization: Yes No Don't Know
19. Is yes, is this based upon
- a) parental recall Yes No
- b) immunisation records Yes No
20. Age at measles immunization (years / months) /

DIAGNOSIS

21. Date of onset of first symptoms / /
22. Date of definitive diagnosis / /
23. Elevated CSF measles antibody titres Yes No Don't Know
24. If available, state CSF titre
25. CSF oligoclonal band Present Absent Don't Know
26. If available, state serum titre
27. Consistent EEG changes Yes No Don't Know
28. If yes, please give details
29. If diagnosed at autopsy, were typical histological features present Yes No Don't Know
30. If yes, please give details

FOLLOW UP

31. May we contact you in 6 months time to get a progress report on your SSPE patient? Yes No
32. Comments

Thank you for completing this questionnaire.

A short follow up questionnaire will be sent in 12 months seeking follow up information. Please return in the reply paid envelope to:

Dr Jeffrey Hanna, Tropical Public Health Unit
PO Box 1103, Cairns QLD 4870
Tel: (07) 503600 Fax: (07) 311 440