Congenital Cytomegalovirus (CMV) Infection

Australian Paediatric Surveillance Unit

If you have any questions about this form, please email SCHN-APSU@health.nsw.gov.au

APSU Office Use Only

Study ID #:

Month/Year Report:

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

Version 3.2: 10.12.2025

REPORTING CLINICIANS DETAILS

1. APSU Dr Code/Name: ☐☐☐☐ / _____

Provide your best organisational email address: _____

2. Date questionnaire completed: ☐☐ / ☐☐ / ☐☐

PATIENT

3. First 2 letters of first name: ☐☐

4. First 2 letters of surname: ☐☐

5. Date of Birth: ☐☐ / ☐☐ / ☐☐

6. Sex: ☐ M ☐ F

7. Postcode: ☐☐☐☐

8. Date of CMV diagnosis: ☐☐ month / ☐☐ year

9. Country of birth of child: ☐ Australia ☐ Other, specify: _____ ☐ DK

10. Mother's country of birth: ☐ Australia ☐ Other, specify: _____ ☐ DK

11. Father's country of birth: ☐ Australia ☐ Other, specify: _____ ☐ DK

12. Is the child of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No ☐ DK

If this patient is primarily cared for by another physician who you believe could report the case or provide additional details, please write their name below and return this form to the APSU. If no other report is received for this child we will contact you for further information

Physician's Name: **Clinic/Hospital:**

CHILD

13. Age of child when CMV first suspected: _____

14. Were there any other abnormalities, congenital infections or other significant conditions present? ☐ Yes ☐ No ☐ DK ***If yes,*** please specify: _____

15. Child's clinical results:

a) CMV IgG serology	☐ Positive	☐ Negative	☐ DK	☐ Not done	Date of test: ☐☐ / ☐☐ / ☐☐
b) IgG avidity	_____ % lab cut-off		☐ DK		Date of test: ☐☐ / ☐☐ / ☐☐
c) CMV IgM serology	☐ Positive	☐ Negative	☐ DK	☐ Not done	Date of test: ☐☐ / ☐☐ / ☐☐
d) Viral culture	☐ Positive	☐ Negative	☐ DK	☐ Not done	Date of test: ☐☐ / ☐☐ / ☐☐
e) Urine CMV PCR	☐ Positive	☐ Negative	☐ DK	☐ Not done	Date of test: ☐☐ / ☐☐ / ☐☐
f) Blood CMV PCR	☐ Positive	☐ Negative	☐ DK	☐ Not done	Date of test: ☐☐ / ☐☐ / ☐☐
g) Newborn Screen *(Guthrie Card)*	☐ Positive	☐ Negative	☐ DK	☐ Not done	Date of test: ☐☐ / ☐☐ / ☐☐

16. Was brain imaging done (e.g. MRI ultrasound)? ☐ Yes ☐ No ☐ DK Date of MRI: ☐☐ / ☐☐ / ☐☐

If imaging performed, were any abnormalities detected
(e.g. calcification, ventricular dilatation, necrosis etc)? ☐ Yes ☐ No ☐ DK ***If yes,*** please specify: _____

MOTHER OF CHILD

17. Gravida: _____ Para: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐ ***OR*** Age: _____

a) CMV IgG serology ☐ Positive ☐ Negative ☐ DK ☐ Not done

b) IgG avidity _____ % lab cut-off ☐ DK Test date: ☐☐ / ☐☐ / ☐☐

c) CMV IgM serology ☐ Positive ☐ Negative ☐ DK ☐ Not done

d) Viral culture ☐ Positive ☐ Negative ☐ DK ☐ Not done

e) Urine CMV PCR ☐ Positive ☐ Negative ☐ DK ☐ Not done

f) Blood CMV PCR ☐ Positive ☐ Negative ☐ DK ☐ Not done

18. Mother's serology performed? ☐ Prior to pregnancy ☐ During pregnancy ☐ After birth ☐ DK ☐ Not done

19. Did the mother suffer illness during pregnancy? ☐ Yes ☐ No ☐ DK ***If yes*, please complete a - d below:**

a) please specify the nature of the illness: _____

b) did she have fever? ☐ Yes ☐ No ☐ DK ***If yes*,** how long did it last? _____days

c) did she have rash? ☐ Yes ☐ No ☐ DK

d) did she have flu-like symptoms? ☐ Yes ☐ No ☐ DK

CLINICAL CONDITIONS PRESENT IN THE CHILD

20. Small for gestational age/intrauterine growth restriction? ☐ Yes ☐ No ☐ DK _____ weeks gestational age/ at birth

21. Was the child asymptomatic and well as a neonate? ☐ Yes ☐ No ☐ DK

22. Has the child had NO symptoms, apart from hearing loss? ☐ Yes ☐ No ☐ DK

23. Was hearing impairment diagnosed? ☐ Yes ☐ No ☐ DK

If yes, ☐ Sensorineural ☐ Unilateral ☐ Bilateral ☐ Other (please specify): _____

24. Was the child symptomatic and unwell as a neonate? ☐ Yes ☐ No ☐ DK

Any diagnosis of:				***If present*, age of occurrence or diagnosis**
25. Hepatitis	☐ Yes	☐ No	☐ DK	_____(wk or mth?)
26. Hepatomegaly	☐ Yes	☐ No	☐ DK	_____(wk or mth?)
27. Jaundice	☐ Yes	☐ No	☐ DK	_____(wk or mth?)
28. Anaemia	☐ Yes	☐ No	☐ DK	_____(wk or mth?)
29. Thrombocytopenia	☐ Yes	☐ No	☐ DK	_____(wk or mth?)
30. Petechiae, purpura	☐ Yes	☐ No	☐ DK	_____(wk or mth?)
31. Pneumonitis	☐ Yes	☐ No	☐ DK	_____(wk or mth?)
32. Myocarditis	☐ Yes	☐ No	☐ DK	_____(wk or mth?)

34. Chorioretinitis ☐ Yes ☐ No ☐ DK _____(wk or mth?)

35. Microphthalmia ☐ Yes ☐ No ☐ DK _____(wk or mth?)

36. Encephalitis ☐ Yes ☐ No ☐ DK _____(wk or mth?)

37. Microcephaly ☐ Yes ☐ No ☐ DK _____(wk or mth?)

38. Seizures ☐ Yes ☐ No ☐ DK _____(wk or mth?)

39. Has there been developmental delay? ☐ Yes ☐ No ☐ DK _____(wk or mth?)

40. Has there been delayed motor milestones? ☐ Yes ☐ No ☐ DK _____(wk or mth?)

41. Has there been abnormality of movement or posture? ☐ Yes ☐ No ☐ DK _____(wk or mth?)

Please specify e.g. spasticity, dyskinesia/ataxia/ hypotonia: _____

42. Has this child been described as having cerebral palsy? ☐ Yes ☐ No ☐ DK _____(wk or mth?)

Please specify if spastic, dyskinetic, ataxic, mixed or other: _____

43. Any other neurological symptoms?

If yes, please specify: _____ _____(wk or mth?)

_____

_____

THERAPY FOR CLINICAL CONDITIONS PRESENT IN THE CHILD

44. Was antiviral treatment given? ☐ Yes ☐ No ☐ DK

45. ***If yes*****,** planned type and length of treatment: _____

Date commenced: ☐☐ / ☐☐ / ☐☐ ☐ NA

42. Has the child died? ☐ Yes ☐ No ☐ DK

If yes**,** date of death: ☐☐ / ☐☐ / ☐☐

Thank you for your assistance with this research project

Please return this case report form ASAP by email to SCHN-APSU@health.nsw.gov.au or via FAX: (02) 9845 3082

Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au
or by mail to: Australian Paediatric Surveillance Unit, Kids Research,
Locked Bag 4001, Westmead NSW 2145
or via Fax: (02) 9845 3082
- even if all the sections have not been completed.

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Faculty of Medicine and Health, The University of Sydney.
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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines