Australian Paediatric Surveillance Unit	APSU Office Use Only	
JAPANESE ENCEPHALITIS IN CHILDREN < 18 YEARS OLD	Study ID #:	
Please contact the APSU by email SCHN-APSU@health.nsw.gov.au if you have any questions about this form		
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 1.0_24/04/2023*	

REPORTING CLINICIANS DETAILS:

Dr Name:	______________________
Phone:	______________________
APSU Code (if known):	______________________
Email:	______________________
Hospital:	______________________
Date case report form completed:	____/____/________

PATIENT DETAILS:

First 2 letters of first name:	____
First 2 letters of surname:	____
Date of Birth:	____/____/________
Sex:	☐ Male ☐ Female
Postcode of family:	________
Country of birth:	☐ Australia ☐ Other, specify: ____________ ☐ Don't know
Ethnicity:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Caucasian ☐ Asian ☐ Pacific Islander ☐ Middle Eastern ☐ African ☐ Other, specify: ____________ ☐ Don't know
Mother's country of birth:	______________________ ☐ DK
Father's country of birth:	______________________ ☐ DK
Any recent overseas travel (please specify where):	______________________ ☐ DK

JAPANESE ENCEPHALITIS CASE DEFINITION (<18 Years):

Date of onset of first symptom or sign *(associated with suspected JEV)*	____/____/________		
Date of onset of fever (≥38.0 ºC):	____/____/________		
Rigors	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Weakness	☐ Yes	☐ No	☐ Unknown
Diarrhoea	☐ Yes	☐ No	☐ Unknown
Vomiting	☐ Yes	☐ No	☐ Unknown
Seizures	☐ Yes	☐ No	☐ Unknown
Altered Mental Status	☐ Yes	☐ No	☐ Unknown
Hemiplegia	☐ Yes	☐ No	☐ Unknown
Tetraplegia	☐ Yes	☐ No	☐ Unknown
Cranial Nerve Palsy	☐ Yes	☐ No	☐ Unknown
Laboratory confirmation of JEV infection	☐ Yes	☐ No	☐ Unknown

Additional comments

Any significant information relating to presentation that is not captured above?

____

____

____

Investigations

Japanese encephalitis virus

Positive IgM antibody test	☐ Yes ☐ No ☐ Unknown
Other diagnostic test performed (e.g., PCR)?	☐ Yes ☐ No ☐ Unknown

Treatment and Outcomes

Hospital Admission

Was the child admitted to hospital	☐ Yes ☐ No ☐ Unknown
Was the child admitted to intensive care or high dependency unit? (ICU or HDU)	☐ Yes ☐ No
Date of ICU admission:	_____/_____/__________
Date of ICU discharge:	_____/_____/__________

Treatment

Which of the following treatments did the child receive?

- Antibiotics	☐ Yes ☐ No
Please specify:	____________________
Specify:	☐ Oral ☐ Parenteral (IM/IV)
- Corticosteroids	☐ Yes ☐ No
Specify:	☐ Oral ☐ Parenteral (IM/IV) ☐ Inhaled ☐ Topical
- Specify other specific treatment(s): *(specify treatment, route & dose)*	____________________
Highest level of respiratory support required?	☐ Invasive ventilation ☐ Non-invasive ventilation CPAP or BiPAP ☐ High flow nasal prongs ☐ Oxygen (L/min) ☐ FiO2 oxygen (%) ☐ No oxygen (During ICU admission)

Discharge & Case Completion

At the time of reporting was the child discharged?	☐ Yes ☐ No
At the time of reporting, what was the child's status	☐ Neurological sequalae before discharge ☐ Discharged ☐ Transferred to other hospital ☐ Still hospitalised at 60 days ☐ Deceased
Date of death	_____/_____/__________
Date of discharge or hospital transfer	_____/_____/__________
Length of stay (days)	____________________

Thank you for your help with this research project.

Please return this case report form to the APSU via email to SCHN-APSU@health.nsw.gov.au
or fax to 02 9845 3082, or mail to Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145

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.