Patient number

Congenital CMV infection study

(ICD-10 P35.1)

Please fill this form using upper case writing

Inclusion criteria

1. Child has a confirmed congenital CMV before 3 weeks of life by amniocentesis PCR, viral culture, CMV early antigen or urine/blood PCR	O yes	O no
OR		
2. Child has a suspected congenital CMV after 3 weeks but under 1 year of life by: a) viral culture/PCR in urine or blood associated with compatible symptoms and/or b) positive IgM serology associated with compatible symptoms	O yes	O no

Exclusion criteria

1. Child has a confirmed **postnatal** CMV acquisition	O yes	O no
2. Stillbirth with confirmed or suspected congenital CMV	O yes	O no

If you answered ***yes*** to the inclusion criteria and ***no*** to both exclusion criteria,then the child is eligible for this study.

Please fill out the next three pages as much as you can.
Thank you very much for the time you will spend answering this form.

If you have any question, please contact:

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Date questionnary completed __.__.____

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Reporting clinician

Institution:
Physician name:
Phone number:

Child's Pediatrician

Physician name:
Address:

Epidemiology

Child's birth date (DD/MM/YYYY): __.__.____   Sex: O Female O Male

Child, CMV diagnostic date: Exact date of diagnosis: __.__.____ **or**

O 1st trimester of pregnancy   O birth to 3 weeks   O 6 months to 1 year after birth
O 2nd trimester of pregnancy   O 3 weeks to 3 months after birth
O 3rd trimester of pregnancy   O 3 months to 6 months after birth

Child's country of birth:

Child ethnicity: O Caucasien O Africa/Middle-Eastern O South America O Asia O Other

Country of origin

- mother   Professional contact w young children O Yes O No O Don't know
- father   Professional contact w young children O Yes O No O Don't know

Mother of child

Gravida: Parity: Year of birth (YYYY)

Mother's CMV laboratory results:

				DD.MM.YYYY
IgG Serology:	O positive	O negative	O not done	date of test: __.__.____
IgM Serology:	O positive	O negative	O not done	date of test: __.__.____
Viral culture:	O positive	O negative	O not done	date of test: __.__.____
Urine PCR:	O positive	O negative	O not done	date of test: __.__.____
Urine Ag:	O positive	O negative	O not done	date of test: __.__.____
Blood PCR:	O positive	O negative	O not done	date of test: __.__.____

Mother's serology done? (tick all that apply)

O prior pregnancy O 1st trimester O 2d trimester O 3rd trimester O after delivery O not done

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Mother of child

Was the mother sick during pregnancy? O yes O no O don't know

please specify the nature of illness

				Which trimester ?			How long (days) ?
Flu-like symptoms?	O yes	O no	O don't know	O 1rst	O 2nd	O 3rd	
Fever?	O yes	O no	O don't know	O 1rst	O 2nd	O 3rd	
Rash?	O yes	O no	O don't know	O 1rst	O 2nd	O 3rd	

Was the mother treated for CMV during pregnancy? O yes O no O dk

If yes, specify

Child

Gestation of child at birth (eg. 37 5/7): weeks /7 days

Were there any other anomalies, other congenital infections or significant conditions present?

O yes O no O don't know If yes, specify

Child's CMV laboratory results:

					D D . M M . Y Y Y Y
Urine early AG:	O positive	O negative	O not done	date of test:	. .
IgG Serology:	O positive	O negative	O not done	date of test:	. .
IgM Serology:	O positive	O negative	O not done	date of test:	. .
Viral culture:	O positive	O negative	O not done	date of test:	. .
Urine PCR:	O positive	O negative	O not done	date of test:	. .
Blood PCR:	O positive	O negative	O not done	date of test:	. .
Cord blood:	O positive	O negative	O not done	date of test:	. .

PCR or Culture

Clinical conditions of the child at birth

				(don't know = dk) If yes, specify:
Small head circumf. for gest age?	O yes	O no	O dk	
Small height for gest age?	O yes	O no	O dk	
Small weight for gest age?	O yes	O no	O dk	
Microcephaly? < P10	O yes	O no	O dk	
Microphtalmia?	O yes	O no	O dk	
Hepatomegaly?	O yes	O no	O dk	
Splenomegaly?	O yes	O no	O dk	

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Clinical conditions of the child (at diagnosis)

(don't know = dk)				If yes, specify
Anemia?	O yes	O no	O dk	
Thrombocytopenia?	O yes	O no	O dk	
Undescended testis?	O yes	O no	O dk	
Seizures?	O yes	O no	O dk	
Petechiae, purpura?	O yes	O no	O dk	
Jaundice?	O yes	O no	O dk	
Encephalitis?	O yes	O no	O dk	
Chorioretinitis?	O yes	O no	O dk	
Cataract?	O yes	O no	O dk	
Deafness?	O yes	O no	O dk	
Hepatitis?	O yes	O no	O dk	
Pneumonia?	O yes	O no	O dk	
Myocarditis?	O yes	O no	O dk	
Intracranial calcification?	O yes	O no	O dk	
Motor developmental delay?	O yes	O no	O dk	
Mental developmental delay?	O yes	O no	O dk	

Treatment and outcome

Was antiviral treatment given? O yes O no O don't know

if yes, which? _____ doses? _____ **per Kg / day**

date started: □□.□□.□□□□ date ended: □□.□□.□□□□

Antiviral treatement complications? _____

Was another treatment given? O yes O no O don't know

if yes, which? _____ doses? _____

Did the child die ? O yes O no O don't know date of death: □□.□□.□□□□

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We will contact you in one year for a follow-up. Many thanks!