` Form Approved
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Human Parechovirus 3 (HPeV3) Investigation

Part I: Medical Chart Abstraction

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Please note that this medical chart review form has 19 pages and contains four parts:
Part A: **demographic information** about the infant who was ill with HPeV3
Part B: information from the medical chart of the **mother for labor, delivery and follow up**
Part C: information from the medical chart of the **infant during delivery and neonatal care**
Part D: information from the medical chart of the infant following **admission for HPeV3 illness (most likely at Children's Mercy Hospital)**

Date of chart abstraction: _____ (MM/DD/YYYY)

Name of person completing form: _____

Name and address of institution where this form was completed:

_____

_____

Part A: HPeV3 case-patient information

First Name: _____ Last (Family) Name: _____

Date of Birth: _____ (MM/DD/YYYY) Sex: ☐Female ☐Male ☐Unknown

Race: ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐American Indian or Alaska Native ☐White

(More than one box can be checked)

Ethnicity: ☐Hispanic ☐Non-Hispanic

First name of parent/guardian: _____

Last (Family) name of parent/guardian: _____

Contact telephone number: _____

Email address: _____

Residence address: _____

_____

Part B: Mother's medical record for labor, delivery and follow up

Medical record number: _____

Hospital name: _____

Hospital floor: _____ Hospital room number _____

Date mother was admitted to hospital: _____ (MM/DD/YYYY)

Date of discharge: _____ (MM/DD/YYYY)

Mother's First Name: _____

Mother's Last (Family) Name: _____

Mother's date of birth: _____ (MM/DD/YYYY) OR Mother's age (yrs) _____

Mother's race: ☐Asian ☐Black ☐Hawaiian/Pacific Islander
☐Native American/Alaskan ☐White ☐Other
(More than one box can be checked)

Mother's ethnicity: ☐Hispanic ☐Non-Hispanic

Mother's telephone number (if different to Part 1): _____

Mother's residence address (if different to Part 1): _____

_____

Mother's type of health insurance _____

Does the mother have any pre-existing medical conditions? ☐Yes ☐No ☐Unknown

If yes, please describe:

Date of delivery: _____ (MM/DD/YYYY) Time of delivery: _____

Delivery ward: _____

Mode of delivery: ☐Vaginal delivery ☐Caesarean Section ☐Unknown

If vaginal, duration of membrane rupture prior to delivery (hours) _____

Was a scalp monitor used during delivery? ☐Yes ☐No ☐Unknown

If yes, was there evidence of its use upon physical examination? ☐Yes ☐No ☐Unknown
(e.g. bruising, laceration)

Was the mother febrile (>38 ℃) during delivery? ☐Yes ☐No ☐Unknown

Was the mother febrile (>38 ℃) in the week before delivery? ☐Yes ☐No ☐Unknown

Did the mother have a rash during delivery? ☐Yes ☐No ☐Unknown

Did the mother have a rash in the week before delivery? ☐Yes ☐No ☐Unknown

If yes to any of the above, please include a description of the rash (eg location, type {maculopapular, vesicular} etc):

Please list any medications prescribed to the mother in hospital (e.g. PRN medications, oxytocin, antibiotics, anesthetics):

Medication	**Dose and route**	**Date Started (MM/DD/YYYY)**	**Date Stopped (MM/DD/YYYY)**

Medication	**Dose and route**	**Date Started (MM/DD/YYYY)**	**Date Stopped (MM/DD/YYYY)**

Please list staff present before and during labor or the delivery, and also post-partum care:

Name	**Job Title**

Any other comments regarding labor, delivery or post-partum care:

Part C: Infant's chart for delivery and neonatal follow up

Medical record number: _____

Hospital name: _____

Infant's First Name: _____ ____

Infant's Last (Family) Name: _____

Date of delivery: _____ (MM/DD/YYYY) Time of delivery: _____

Length of gestation (weeks): _____

Infant's Birth Weight (lbs): _____ ☐Estimated ☐Measured ☐Unknown

Was resuscitation required at birth? ☐Yes ☐No ☐Unknown

If yes: ☐Suction ☐Oxygen ☐Positive pressure ventilation (PPV) ☐Intubation

Which nursery was the infant in after birth? _____

How long was the infant in the nursery? _____ hours/days (please circle) ☐Unknown

Please list any staff who cared for the infant in the nursery:

Name	**Job Title**

Please list any medications prescribed to the infant during neonatal care:

Medication	**Dose and route**	**Date Started (MM/DD/YYYY)**	**Date Stopped (MM/DD/YYYY)**

Please describe any treatment regimens or interventions provided to the infant during neonatal care (e.g. supplemental oxygen, respiratory therapy, supplemental feeding, circumcision, PRN meds etc):
Do not include intravenous fluids

Any other comments regarding the infant's delivery or neonatal care:

Discharge date: _____ (MM/DD/YYYY)

Status upon discharge: _____

_____

_____

Part D: Medical chart of infant's hospitalization for HPeV3 illness

Medical record number: _____

Infant's First Name: _____

Infant's Last (Family) Name: _____

Infant's date of birth: _____ (MM/DD/YYYY)

Date of testing for HPeV: _____(MM/DD/YYYY)

Test type: _____ Results: _____

Admission date to hospital of initial presentation: _____ (MM/DD/YYYY)

Transfer date from hospital of initial presentation: _____ (MM/DD/YYYY)

Admission date to secondary facility: _____ (MM/DD/YYYY)

Transferred from:

Hospital name and nursery: _____

Transferred to:

Hospital name and nursery: _____

Please describe any patient information available from a referring facility, if applicable:

Did the infant have any underlying medical conditions? ☐Yes ☐No ☐Unknown

If yes, please describe:

Are outpatient visits prior to becoming ill noted in the chart? ☐Yes ☐No ☐Unknown

If yes, please describe:

Is family history of neurologic illness, including seizures, noted in the chart? ☐Yes ☐No ☐Unknown

If yes, please describe:

Please list any medications prescribed to the infant **before** hospitalisation (e.g. OTC meds used by parents, medications discontinued prior to hospitalisation):

Medication	**Dose and route**	**Date Started (MM/DD/YYYY)**	**Place of administration**

Signs and Symptoms

Date of first clinical symptoms: _____ (MM/DD/YYYY)

As part of this illness, does the infant have or has the infant had any of the following:

Fever

Fever (>38 ℃)…… ☐Yes ☐No ☐Unknown

If yes, what was the highest temperature? _____ ℃

Temperature <35 ℃…… ☐Yes ☐No ☐Unknown

If yes, what was the lowest temperature? _____ ℃

Rash

Skin rash…… ☐Yes ☐No ☐Unknown

If yes, please describe (eg. Location, type {maculopapular, vesicular} etc):_____

_____

_____

Redness on feet or hands …… ☐Yes ☐No ☐Unknown

Ulcers or lesions in mouth…… ☐Yes ☐No ☐Unknown

Neurologic

Focal seizures/convulsions…… ☐Yes ☐No ☐Unknown

Generalized seizures/convulsions…… ☐Yes ☐No ☐Unknown

Intractable seizures/convulsions…… ☐Yes ☐No ☐Unknown

Myoclonic jerk…… ☐Yes ☐No ☐Unknown

Tremors…… ☐Yes ☐No ☐Unknown

Limb weakness/monoparesis…… ☐Yes ☐No ☐Unknown

Stiff neck…… ☐Yes ☐No ☐Unknown

Bulging fontanelle…… ☐Yes ☐No ☐Unknown

Lethargy…… ☐Yes ☐No ☐Unknown

Irritability…… ☐Yes ☐No ☐Unknown

Inconsolable crying…… ☐Yes ☐No ☐Unknown

Cranial nerve palsy…… ☐Yes ☐No ☐Unknown

Respiratory

Cough (dry, productive)…… ☐Yes ☐No ☐Unknown

Secretions…… ☐Yes ☐No ☐Unknown

Runny nose…… ☐Yes ☐No ☐Unknown

Sneezing…… ☐Yes ☐No ☐Unknown

Difficulty breathing…… ☐Yes ☐No ☐Unknown

Wheezing…… ☐Yes ☐No ☐Unknown

Rales/crackles/crepitations…… ☐Yes ☐No ☐Unknown

Tachypnea (as assessed and recorded by provider)… ☐Yes ☐No ☐Unknown

If yes, please indicate rate _____ (RR/min)

Frothy secretions from mouth…… ☐Yes ☐No ☐Unknown

Hemoptysis…… ☐Yes ☐No ☐Unknown

Respiratory failure…… ☐Yes ☐No ☐Unknown

Oxygen given…… ☐Yes ☐No ☐Unknown

If yes, how was it administered? _____

Intubation…… ☐Yes ☐No ☐Unknown

Retractions, nasal flaring…… ☐Yes ☐No ☐Unknown

Cardiovascular

Bradycardia (as assessed and recorded by provider).. ☐Yes ☐No ☐Unknown

If yes, please indicate rate _____ (HR/min)

Tachycardia (as assessed and recorded by provider).. ☐Yes ☐No ☐Unknown

If yes, please indicate rate _____ (HR/min)

Variable heart rate (tachy/brady)…… ☐Yes ☐No ☐Unknown

Cyanosis…… ☐Yes ☐No ☐Unknown

Mottled skin…… ☐Yes ☐No ☐Unknown

Arrhythmia…… ☐Yes ☐No ☐Unknown

Abnormal heart sounds…… ☐Yes ☐No ☐Unknown

If yes, please describe _____

Hypotension/shock…… ☐Yes ☐No ☐Unknown

Gastrointestinal

Vomiting…… ☐Yes ☐No ☐Unknown

Watery stools…… ☐Yes ☐No ☐Unknown

Constipation…… ☐Yes ☐No ☐Unknown

Abdominal distention…… ☐Yes ☐No ☐Unknown

Abdominal pain…… ☐Yes ☐No ☐Unknown

Jaundice…… ☐Yes ☐No ☐Unknown

Poor feeding…… .. ☐Yes ☐No ☐Unknown

Others

Conjunctivitis…… ☐Yes ☐No ☐Unknown

Bleeding…… ☐Yes ☐No ☐Unknown

Persistent crying…… ☐Yes ☐No ☐Unknown

Lymphadenopathy…… ☐Yes ☐No ☐Unknown

Please describe any other symptoms not listed above, or any of note:

Laboratory Exams

Please list here all laboratory findings from admission:

Specimen Collection Date (MM/DD/YYYY)	**Specimen type**	**Test type**	**Results (include reference range)**
	Serum	AST(SGOT), ALT(SGPT), GGT	
	Serum	T. BILI, direct bili	
	Serum	BUN, creatinine	
	Serum	Glucose	
	Serum	Creatinine Kinase	
	Serum	Sodium	

	Blood	HB/HCT	
	Blood	WBC	
	Blood	Neutros	
Specimen Collection Date (MM/DD/YYYY)	**Specimen type**	**Test type**	**Results (include reference range)**
	Blood	Bands	
	Blood	Lymphs	
	Blood	Monos	
	Blood	EOS	
	Blood	PLTS	
	Blood	Culture	
	Blood	ANC	
	Blood	LDH	
	Blood	CRP	
	Blood	ESR	
	NP/OP/Throat	Culture	
	Rectal/stool	Culture	
	Eye	Culture	
	Vesicle	Culture	
	Urine	Culture	
	Urine	UA	
	CSF	Opening pressure	
	CSF	RBC	
	CSF	WBC	

	CSF	Neutro	
	CSF	Lympho	
	CSF	EOS	
Specimen Collection Date (MM/DD/YYYY)	**Specimen type**	**Test type**	**Results (include reference range)**
	CSF	Protein	
	CSF	Glucose	
	CSF	Gram stain	
	CSF	Culture	
		HPeV3-specific PCR	
		Enterovirus-specific PCR	
		HSV-specific PCR	
		Other virus PCR	
Please describe below any other unusual laboratory results at admission			

Radiologic Exams

Please describe here all radiological exams requested:

Exam date (MM/DD/YYYY)	**Test type**	**Results**
	CXR	
	CT	
	MRI	
	Echocardiography	
	Ultrasound	
	EEG	
	Plain abdominal radiographs	

Medication and Treatment

Was the infant placed in the neonatal intensive care unit (NICU)? ☐Yes ☐No ☐Unknown

If yes, admission date: _____ Discharge date: _____ (MM/DD/YYYY)

Was the infant placed in the pediatric intensive care unit (PICU)? ☐Yes ☐No ☐Unknown

If yes, admission date: _____ Discharge date: _____ (MM/DD/YYYY)

Please list any medications prescribed to the infant in hospital:

Medication	**Dose and route**	**Date Started (MM/DD/YYY)**	**Date Stopped (MM/DD/YYY)**

Please describe any other treatment regimens or interventions provided to the infant in hospital (e.g. supplemental oxygen, respiratory therapy, supplemental feedings, PRN meds etc):
Do not include intravenous fluids

Discharge

Is infant still in hospital? ☐Yes ☐No If no, discharge date: _____(MM/DD/YYYY)

Status upon discharge: _____

Died: ☐Yes ☐No ☐Unknown If yes, date of death _____ (MM/DD/YYYY)

Discharge diagnosis: _____

_____

_____

_____

_____

Other information

Please describe here any other information that you feel may be important or unusual, with regard to the infant's stay in hospital:

End of medical chart abstraction form