

# 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:



<b>Medication</b>	<b>Dose and route</b>	<b>Date Started (MM/DD/YYYY)</b>	<b>Date Stopped (MM/DD/YYYY)</b>

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

<b>Name</b>	<b>Job Title</b>

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 °C)..... Yes No Unknown

If yes, what was the highest temperature? \_\_\_\_\_ °C

Temperature <35 °C..... Yes No Unknown

If yes, what was the lowest temperature? \_\_\_\_\_ °C

**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:

<b>Specimen Collection Date (MM/DD/YYYY)</b>	<b>Specimen type</b>	<b>Test type</b>	<b>Results (include reference range)</b>
	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	
<b>Specimen Collection Date (MM/DD/YYYY)</b>	<b>Specimen type</b>	<b>Test type</b>	<b>Results (include reference range)</b>
	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	
<b>Specimen Collection Date (MM/DD/YYYY)</b>	<b>Specimen type</b>	<b>Test type</b>	<b>Results (include reference range)</b>
	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:

<b>Exam date (MM/DD/YYYY)</b>	<b>Test type</b>	<b>Results</b>
	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:

<b>Medication</b>	<b>Dose and route</b>	<b>Date Started (MM/DD/YYYY)</b>	<b>Date Stopped (MM/DD/YYYY)</b>

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