` Form Approved
OMB No. 0920-1011
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Human Parechovirus 3 (HPeV3) Investigation

Part I: Medical Chart Abstraction

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