

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: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown |
| Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White |
| (More than one box can be checked) | |
| Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> 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 °C) during delivery? Yes No Unknown

Was the mother febrile (>38 °C) 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) |
|------------|----------------|------------------------------|------------------------------|
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| Medication | Dose and route | Date Started (MM/DD/YYYY) | Date Stopped (MM/DD/YYYY) |
|-------------------|-----------------------|--------------------------------------|--------------------------------------|
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Please list staff present before and during labor or the delivery, and also post-partum care:

| Name | Job Title |
|-------------|------------------|
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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 |
|------|-----------|
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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) |
|------------|----------------|------------------------------|------------------------------|
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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 |
|------------|----------------|---------------------------|-------------------------|
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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:

| 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 | |

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|--|--------------------------|------------------|--|
| | 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 | |

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|---|--------------------------|--------------------------|--|
| | 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 | | | |
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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 | |
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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/YYYY) | Date Stopped (MM/DD/YYYY) |
|-------------------|-----------------------|--------------------------------------|--------------------------------------|
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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