

Roche Pregnancy Registry: WA40063




Pediatric Follow-up 3 - Single Birth



























Site #

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Patient #

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Date of Contact	
Date of Contact	<input type="text"/>  
Reporter of Information	<input type="radio"/> Patient <input type="radio"/> Obstetrician <input type="radio"/> Neurologist  <input type="radio"/> Infant HCP <input type="radio"/> Other
<input type="button" value="Revert"/> <input type="button" value="Save"/>	

Infant Characteristics		
Infant age	(auto calculated)	 (99)
Infant's current:		
Date of measurement collection	<input type="text"/> 	
Weight	<input type="text"/>	 (999.99)
Weight Unit	<input type="text"/>	
Length	<input type="text"/>	 (999.99)
Length Unit	<input type="text"/>	
Head circumference	<input type="text"/>	 (99.99)
Head circumference Unit	<input type="text"/>	
Are laboratory values available (<i>CD19, neutrophil, lymphocyte, white blood cell, immunoglobulin, platelet counts</i>)?	<input type="radio"/> No <input type="radio"/> Yes	
Congenital malformations noted?	<input type="radio"/> No <input checked="" type="radio"/> Yes	
If Yes, please select all that apply:		
Chromosomal defects, known mendelian inherited disorders, Syndromes and DiGeorge Sequence	<input type="checkbox"/>	
Amniotic bands	<input type="checkbox"/>	
Metabolic disorders (e.g. phenylketonuria, G6PD deficiency)	<input type="checkbox"/>	
Structural malformations	<input checked="" type="checkbox"/>	
CENTRAL NERVOUS SYSTEM		
Anencephaly	<input type="checkbox"/>	
Encephalocele	<input type="checkbox"/>	
Neural tube defects	<input type="checkbox"/>	
Spina bifida	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	
Other, specify	<input type="text"/>	
CARDIOVASCULAR		
Coarctation of the aorta	<input type="checkbox"/>	
Endocardial cushion defect	<input type="checkbox"/>	
Ventricular septal defect	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	
Other, specify	<input type="text"/>	

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ORAL CLEFTS		
Cleft palate only	<input type="checkbox"/>	
Cleft lip with or without cleft palate	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	
Other, specify	<input type="text"/>	
GENITAL ORGANS		
Hypospadias	<input type="checkbox"/>	
Undescended testicle	<input type="checkbox"/>	
Other	<input type="checkbox"/>	
UPPER ALIMENTARY TRACT & GASTROINTESTINAL SYSTEM		
Anal atresia/stenosis	<input type="checkbox"/>	
Pyloric stenosis	<input type="checkbox"/>	
Small intestine atresia/stenosis	<input type="checkbox"/>	
Tracheo-esophageal fistula	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	
Other, specify	<input type="text"/>	
URINARY SYSTEM		
Cystic kidney disease	<input type="checkbox"/>	
Extra or horseshoe kidney	<input type="checkbox"/>	
Renal agenesis & dysgenesis	<input type="checkbox"/>	
Renal collecting system anomalies	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	
Other, specify	<input type="text"/>	
MUSCULOSKELETAL SYSTEM		
Clubfoot	<input type="checkbox"/>	
Craniosynostosis	<input type="checkbox"/>	
Diaphragmatic hernia	<input type="checkbox"/>	
Gastroschisis	<input type="checkbox"/>	
Limb reduction defects	<input type="checkbox"/>	
Omphalocele	<input type="checkbox"/>	
Polydactyly	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	
Other, specify	<input type="text"/>	
OTHER		
Inguinal hernia	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	
Other, specify	<input type="text"/>	
Any change in infant feeding since last contact?	<input type="radio"/> No <input checked="" type="radio"/> Yes	
Infant feeding	<input type="text"/>	

For entry of weight units, please indicate whether 'kg' or 'lbs', for entry of length and head circumference please indicate whether 'cm' or 'inches.'

Infant Feeding: Please select from 'breastfed', 'formula', combination breastfed/formula, other, specify

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Infant Labs									
Date of sample collection				<input type="text"/>					
Test Name	Not Done	Result	Units	Other, specify	Low	High	Clinically Significant		
CD19	<input type="checkbox"/>	<input type="text"/>	(99999.99)	<input type="text"/>	<input type="text"/>	(99999.99)	<input type="text"/>	(99999.99)	<input type="checkbox"/>
Neutrophil	<input type="checkbox"/>	<input type="text"/>	(99999.99)	<input type="text"/>	<input type="text"/>	(99999.99)	<input type="text"/>	(99999.99)	<input type="checkbox"/>
Lymphocyte	<input type="checkbox"/>	<input type="text"/>	(99999.99)	<input type="text"/>	<input type="text"/>	(99999.99)	<input type="text"/>	(99999.99)	<input type="checkbox"/>
White Blood Cell	<input type="checkbox"/>	<input type="text"/>	(99999.99)	<input type="text"/>	<input type="text"/>	(99999.99)	<input type="text"/>	(99999.99)	<input type="checkbox"/>
Immunoglobulin	<input type="checkbox"/>	<input type="text"/>	(99999.99)	<input type="text"/>	<input type="text"/>	(99999.99)	<input type="text"/>	(99999.99)	<input type="checkbox"/>
Platelet counts	<input type="checkbox"/>	<input type="text"/>	(99999.99)	<input type="text"/>	<input type="text"/>	(99999.99)	<input type="text"/>	(99999.99)	<input type="checkbox"/>
Blood Lead Concentration Test	<input type="checkbox"/>	<input type="text"/>	(99.99)	<input type="text"/>	<input type="text"/>	(99999.99)	<input type="text"/>	(99999.99)	<input type="checkbox"/>

Infant Vaccinations (Add Page #!)			
Sequence Number			
Vaccination Name	<input type="text" value="Other"/>		
Other, specify	<input type="text"/>		
Vaccination Date	<input type="text"/>		<input type="text" value="Unknown"/>

(Remain at this screen to add more)

Please select from the below codelist:

Diphtheria (D)

Diphtheria,tetanus & acellular pertussis (DTaP)

Haemophilus Influenzae type b Infection (HiB)

Hepatitis A (HepA)

Hepatitis B (HepB)

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Influenza (IIV)

Measles (MEAS)

Measles, mumps, rubella (MMR)

Meningococcal disease (MenC, MenACWY-D, MenACWY-CRM)

Mumps (MUMPS)

Pertussis (acp)

Pneumococcal disease (PCV, PCV13)

Poliomyelitis (IPV)

Rotavirus (RV, ROTA)

Rubella (RUBE)

Tetanus (TT)

Varicella (VAR)

Other, Specify Other _____-