NHI:……. Patient Label

Adverse and Serious Adverse Event Summary (Record any adverse event that occurred)

1. Notification of AE or SAE: Date.....Time.....

1.1Adverse event medical term/ diagnosis	1.2 Date of Onset or Admission	1.3 Date of Resolution or Discharge	1.4 Was the event serious	1.5 Action taken due to AE *(tick at least one)*	1.6 Relationship to study procedures	1.7 Outcome
☐ SSU or Hospital admission	__/__/__	__/__/__ ☐ Not resolved	☐ Yes ☐ No	☐ None ☐ Additional monitoring required ☐ Patient discontinued in study ☐ Other *(Specify)*.....	☐ None ☐ Remote ☐ Possible ☐ Probable ☐ Definite	☐ Recovered ☐ Ongoing ☐ Recovered with sequelae ☐ Death ☐ Unknown

2. **Serious Event Criteria:** (tick at least one) ***Immediately notify principal investigator.***
- 2.1 ☐ Death
- 2.2 ☐ Life threatening (ICU)
- 2.3 ☐ Prolongation of existing hospitalisation
- 2.4 ☐ Important medical event
- 2.5 ☐ Persistent or significant disability/incapacity
- 2.6 ☐ Required inpatient hospitalisation (>10 days), admission date.....

3. Principal Investigator notified *Date*.....

(Office use only)

4. Ethics committee notified: *Date*..... ☐ Not required

AE num..... SAE num.....

Additional Comments**.....**

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Healthy Lungs Study Adverse Event and Serious Adverse Event Guideline

Adverse Events (AE)

An adverse event is defined as an unexpected medical event in a study participant resulting in a hospital admission, including admission to the short stay unit (SSU), within the Auckland region.

Or an unexpected medical occurrence as a result of the administering or prescribing a pharmaceutical product at a Healthy Lungs study clinic.

Note: Emergency department presentations that don't result in a hospital admission are not recorded as adverse events

All adverse experiences observed by the investigator or one of the clinical research staff, or reported by the patient's parents/guardians spontaneously *or* in response to a direct question, that occur during the study period or up to one month after will be evaluated by the investigator and noted on the adverse event CRF.

Serious Adverse Event (SAE)

A SAE is defined as any event that is fatal, life-threatening, permanently disabling, incapacitating or results in prolonged hospitalisation (greater than 10 days), and/or admission to ICU/PICU. SAE includes death during the study period, any other event not mentioned that jeopardises the patient or requires medical or surgical intervention.

Note: SAEs will be reported for both intervention and control groups.

Screening for AE's and SAE's

- **Primary Care Respiratory Clinics:** Report any event that fits AE or SAE definition observed by clinic staff or reported by a parent/legal guardian or person bringing the child to clinic. ***Exception:*** *If a Kidz First Emergency department (ED) presentation or a hospital admission the Kidz First research nurses will report it however confirm with project manager that it has been reported.*
- **Kidz First Research Nurses:** Monitor for AE's and SAE's when completing screening for ED and hospital admissions for control and intervention groups.

Reporting AEs and SAEs:

- **AEs** do not require urgent notification, they will be reviewed weekly by PI/s or delegated person. File in the AE folder and move to patient file once reviewed.
- **SAEs need to be reported within 24 hrs** to principal investigators or if not possible to contact one of the PI's contact the study project manager or a study investigator by telephone.

Note: The principal investigator will also provide a summary report of the SAE to the ethics committee and other regulatory bodies.

Completion of the AE/SAE CRF: Report only one event on each form.

When reporting an AE or SAE you may not be able to complete the form until the event is resolved or the data collection period for the patient has ended. Complete all parts of the form that you can at that moment in time. To ensure the principal

investigator/s are able to accurately assess severity and ongoing actions required attach all relevant reports and provide a summary in the additional comments section.

1. Record the date and time you were notified or became aware of the AE/SAE.

1.1 Adverse event medical term/diagnosis: Record the medical term that best describes the AE or SAE in one or two words. You can list a symptom if that is the only information available. This term can be reviewed at a later date when more information is available.
1.2 Date of onset or hospital admission: This date refers to the onset of the child's first symptoms, illness and/or event relating to this event. If the AE is a hospital admission record the date of arrival in Emergency Department that resulted in the admission to hospital.
1.3 Date of resolution: List the date the symptoms/illness or event ended. Mark as unresolved if the symptoms are continuing at the completion of the study period (i.e. end of the two year follow up of that enrolled child). If the AE is a hospital admission record the date of discharge from hospital.
1.4 Was the event serious: Indicate if you think the event fits the serious definition provided above or in your clinical judgement should be considered a serious adverse event.
1.5 Action taken: Record any action taken as a result of the event. Tick 'none' if no action required.
1.6 Relationship to study procedures: Assess the relationship of the event to actions taken as per study procedures outlined in the study protocol. Consider; the temporal relationship of the event to the study procedures undertaken, the event timing and when the study procedures were undertaken and whether an alternative aetiology has been identified.

Assessments indicating an unlikely relationship:
None: The event is related to an aetiology other than the study procedures.
Remote: The event is unlikely to be related to the study procedures.
Possible: There is an association between the event and study procedures and this event could be related.

Assessments indicating a likely relationship:
Probable: There is an association between the event and study procedures. The event could not be reasonably explained by known characteristics of the child's clinical status or an alternative aetiology.
Definite: There is definite association between the event and study procedures. All other aetiology has been ruled out.

1.7 Outcome: Usually completed after the initial report. At the end of the event (either resolution and/or end of study) indicate the conclusion and/or long term effect of the event.

2. Serious Event Criteria: If a serious event, indicate why the event fits the serious criteria. ***Note:*** *All SAEs must be reported within 24 hours of you becoming aware of the event.*

3. Principal Investigator notified: Record the date that the PI or delegated representative was notified.

Community Health Worker Assessment Date: _____

Location: ☐ Patients home ☐ Hospital ☐ Community respiratory clinic
☐ Other home ☐ Secondary/tertiary clinic ☐ Phone call

Number of attempts to contact family: _____ *(number)*

	Assessment Complete Y/N	Follow up required
Respiratory	N/A	☐Yes ☐No
Nutrition		☐Yes ☐No
Oral Health	N/A	☐Yes ☐No
Skin	N/A	☐Yes ☐No
Hearing	N/A	☐Yes ☐No
Immunisation	N/A	☐Yes ☐No
Smoking Cessation		☐Yes ☐No
Housing		☐Yes ☐No
Social		☐Yes ☐No
Other_____		☐Yes ☐No

*Reason for follow up*_____
_____
_____

Date: _____ Time: _____ or ☐ To be arranged

With: ☐Community Health Worker
☐Clinic Nurse
☐GP
☐Respiratory clinic Doctor/Nurse Practitioner

Support provided:

Taxi chit provided	☐Yes	☐No
Petrol voucher provided	☐Yes	☐No
If Yes, Amount $ ___ x ___ number given		
Community Services Card application	☐Yes	☐No
NRT prescribed	☐Yes	☐No
Other *(Specify)* _____	☐Yes	☐No

Referral to additional services:

				Complete	
☐Family safety *(select which)*	Child Protection Services	☐Yes	☐No	☐Yes	☐No
	Child Youth and Family	☐Yes	☐No	☐Yes	☐No
	Family Violence	☐Yes	☐No	☐Yes	☐No
	Woman's Refuge	☐Yes	☐No	☐Yes	☐No
☐Budgeting *(select which)*	IRD - Working for families	☐Yes	☐No	☐Yes	☐No
	WINZ	☐Yes	☐No	☐Yes	☐No
☐Housing *(select which)*	CMDHB - Snug Homes	☐Yes	☐No	☐Yes	☐No
	Habitat for Humanity - Brush with Kindness	☐Yes	☐No	☐Yes	☐No
	Housing NZ - Healthy Housing	☐Yes	☐No	☐Yes	☐No
	Housing NZ - Other	☐Yes	☐No	☐Yes	☐No
	Warm up Manukau	☐Yes	☐No	☐Yes	☐No
☐Other *(select which)*	CMDHB – Smokefree	☐Yes	☐No	☐Yes	☐No
	Plunket	☐Yes	☐No	☐Yes	☐No
	Other *(Specify)*_____	☐Yes	☐No	☐Yes	☐No
	Other *(Specify)*_____	☐Yes	☐No	☐Yes	☐No

Healthy Lungs Intervention study NHI:……

Did Not Attend Clinic **Date: / /** **Patient Label**

1. **Did patient attend respiratory clinic:** ☐Yes ☐**No**
   If No, *Select which clinic(s) not attended*

☐Clinic One (1 month)	☐Clinic six (18 months)
☐Clinic Two (4.5 months)	☐Clinic seven (22 months)
☐Clinic Three (8 months)	☐Final clinic (24 months)
☐Clinic Four (11.5 months)	☐Other follow up visit
☐Clinic Five (15 months)	☐Secondary/Tertiary clinic No. of clinics missed: _____

2. Attempts made to contact family for another appointment? ☐**Yes** ☐No *(go to question 4)*

2.1 **If Yes,** Who contacted family?
- ☐Community Health Worker
- ☐Study Community Clinic Nurse
- ☐Primary Care Clinic Receptionist
- ☐CMDHB Nurse
- ☐Other *(Specify)*_____

2.2 Type of contact made: *(tick at least one)*
- ☐Home visit No. ____
- ☐Phone call No. ____
- ☐Text message No. ____
- ☐Letter No. ____

2.3 Total number of attempts made _____

2.4 Was the patient present for home visit? ☐Yes ☐No ☐N/A

2.5 External agency contacted ☐**Yes** ☐No
If Yes, *(Specify)* _____ _____

2.6 Family agreed to attend another clinic?

☐Unable to make contact

☐Yes, Date ___/___/___

☐No, Reason _____

_____

_____

3. **Will future attempts be made to contact this family?**
   3.1 ☐**No** (if you tick no this confirms this patient is lost to follow up and will no longer be booked for the research clinics)
   3.2 ☐**Yes,** *(Insert when and who will contact the family)*

Date ___/___/___ *Whom* _____

4. Follow up with Community Health Worker? ☐Yes ☐No
   *Reason for follow up*_____

_____

Date: _____ Time: _____ or ☐ To be arranged

Additional Comments: _____

_____

_____

Healthy Lungs- Housing

Current housing situation (tenure): This residence is where the participant and their family live most of the time, their current residence:

- **Owned by myself or family trust** – The house is owned by the occupant (directly or through a family trust).
- **Owned by another person living in the house** – Includes situations where the participant is staying with family or friends, where one of the residents owns the house.
- **Rented from family** – The housing is rented from a family member who manages the property and receives the rent (directly or sometime through a specialist property management company).
- **Rented from Housing New Zealand** – The house is rented from Housing New Zealand which manages the property and receives the rent. This housing could by state-owned (the majority) or privately owned (there are some instances of this). The main identifier for this type of rental housing is that the tenant will have a Housing New Zealand property manager.
  Ex-State housing that is now owned by one of the occupants or has been sold off and is now managed by a private landlord is not included in this category.
- **Rented from Council** – The house is rented from the Auckland Council which manages the property and receives the rent. This type of rental housing is mainly occupied by pensioners and the numbers are relatively small. These units are largely located in central Auckland.
- **Rented from private landlord** – The housing is rented from a private landlord who manages the property and receives the rent (directly or sometime through a specialist property management company). This housing situation will be very common. Some low income tenants receive an accommodation supplement to assist them paying their rent, but they are still considered to be living in private rental housing.
- **Long term care**: **rest home** – Provides housing for relatively independent, usually elderly, tenants.
- **Long term care**: **private hospital** – Provides institutional care for tenants with relatively high needs for assistance and nursing care.
- **Other housing situation (tenure)** - such as living in a boarding house, hostel, night shelter, caravan, car, or on the streets. The housing situation should be specified.

  Where a participant occupies a sleepout which is on the same site as a main home, the housing tenure recorded should by that of the main home. Where the participant responds that they are living with family, record the tenure of the family home.

14.6 Current housing conditions: Please ask the participant / family member / caregiver about the conditions of the house or flat where they (or the participant) currently lives. Try to ask the questions in a consistent way, as written on the questionnaire, or adjusted if the person answering the questions is a parent, caregiver, or other person:
But if they person <u>asks</u> for more explanation feel free to tell them more.

- *Is their home usually colder than they would like?*
  If they could have the house warmer and it did not cost anything would they have it a bit warmer?

- *During the last month, has their home ever felt so cold that they have shivered inside?*
  By shivering we mean either the teeth vibrating or the shuddering that comes from exposure to cold

- *Does their home smell mouldy or musty?*
  If the house has ever or sometimes had a mouldy / musty/ damp **<u>smell</u>**
- *Is there mould on the walls or ceilings in bedrooms or living areas?*
  If they normally have mould or have recently (past year) had mould please tick yes
  This question excludes bathrooms and laundries (unless someone sleeps there)

- *Are the walls or ceilings damp in the bedrooms or living areas?*

This refers to anytime in the last year

This question excludes, bathrooms and laundries where walls are commonly damp from condensation (unless the participant sleeps in them)

Follow-up Clinic Visits

Patient Label

Date of Clinic _____

(Aim: 14 weeks from date of last clinic)

1. Confirmed details: ☐No ☐Yes
   1.1 Relation to child: ☐Mother ☐Father ☐Grandparent ☐Aunt/Uncle ☐Other

Parental Questionnaire

2. Did the following symptoms completely disappear following study enrolment?

2.1 Cough	☐**No**	☐Yes	☐Didn't have
2.1.1 **If No,** Nature of cough: ☐Dry ☐Wet ☐Unsure			
2.2 Wheeze	☐No	☐Yes	☐Didn't have

3. Has the child had any new illnesses since the last clinic visit?

3.1 Cough	☐No	☐Yes
3.1.1 **If Yes,** Nature of cough: ☐Dry ☐Wet ☐Unsure		
3.2 Wheeze	☐No	☐Yes
3.3 Lower respiratory infection	☐No	☐Yes
3.4 Upper respiratory infection	☐No	☐Yes
3.5 Ear infection	☐No	☐Yes
3.6 Skin infection	☐No	☐Yes
3.7 Gastroenteritis	☐No	☐Yes
3.8 Fever unknown cause	☐No	☐Yes
3.9 Other: *(Specify)*_____	_____	_____

4. Has the child received any **new** antibiotics since the last **scheduled** clinic visit? ☐No ☐Yes

5. **Since the last clinic visit has the child visited;** *(Reason/Date)*

5.1 General Practitioner	☐No	☐Yes	_____
5.2 Well Child Provider	☐No	☐Yes	_____
5.3 Kidz First Emergency Care	☐No	☐Yes	_____
5.4 Starship Children's Emergency Care	☐No	☐Yes	_____
5.5 Admitted to Kidz First Ward	☐No	☐Yes	_____
5.6 Admitted to Starship Hospital	☐No	☐Yes	_____
5.7 Admitted to other Hospital	☐No	☐Yes	_____
5.8 Other: *(Specify)* _____	☐No	☐Yes	_____

6. **Immunisation (Update patient imms schedule)**
   6.1 Immunisations up to date? ☐No ☐Yes ☐Too young ☐Unknown

7. **Oral Health**

7.1 Has your child had a dental (teeth) review since last clinic visit?

☐No ☐**Yes**

7.1.2 **If Yes,** Did they find dental caries ☐No ☐Yes ☐Unsure

If Yes, complete Oral Health intervention form.

8. **Nutrition**

8.1 Has the child stopped breast milk feeding since the last clinic?

☐No ☐Unsure ☐N/A ☐**Yes**

If Yes; *(tick at least one)*

8.1.1 Breast milk fed until_____ months of age

8.1.2 Duration of exclusive breast milk feeding_____ months of age ☐N/A

9. **Smoking**

9.1 Number of current smokers in the house_____*(insert number)*

9.2 Do you smoke (If yes complete Q. 9.2.1) ☐No ☐Yes

9.2.1 Are you currently enrolled in a cessation programme ☐No ☐Yes

9.2.2 Do you want smoking cessation support? Yes = Int form ☐No ☐Yes

10. **Housing**

10.1 Has the child moved residence since last clinic visit? ☐No ☐Yes

10.2 Does your child spend more than one night per week at another address ☐No ☐Yes

Clinical Examination

11. **Date of Examination:** _____

12. **Observations**

12.1Temp	12.2 Resp rate per min	12.3 Heart rate per min	12.4 Oxygen sats on air	12.5 Weight	12.6 Length / Height	12.7 Work of breathing
_____	_____	_____	_____% ☐N/A	_____Kg	_____CM	☐Normal ☐Mild ☐Moderate ☐Severe

13. **Examination of Teeth**

13.1 Examination of teeth completed?

☐No ☐**Yes**

If Yes, *(tick at least one)*

13.1.1 Dental caries present ☐No ☐Yes

13.1.2 Previous fillings present ☐No ☐Yes

14. Observations/Assessment completed by _____ *(Initial)*

Nursing Summary/Notes:

15. **Respiratory Examination** *(tick at least one)*

15.1 Normal	☐No	☐Yes	15.6 Chest recession	☐No	☐Yes
15.2 Stridor	☐No	☐Yes	15.7 Chest wall deformity	☐No	☐Yes
15.3 Wheeze	☐No	☐Yes	15.8 Clubbing	☐No	☐Yes
15.4 Crackles	☐No	☐Yes			
15.5 Other *(Specify)* _____	_____		_____		
15.9 Nasal discharge	☐No	☐Yes			
15.10 Pharyngitis	☐No	☐Yes			
15.11 Enlarged tonsils	☐No	☐Yes			

16. **Cough during examination?** ☐No cough ☐Dry cough ☐Wet cough

17. **Examination of the ears**

17.1 **Right Ear** *(tick at least one)*

17.1.1 ☐Normal
17.1.2 ☐Abnormal
17.1.3 ☐Examination not performed

17.2 **Left Ear** *(tick at least one)*

17.2.1 ☐Normal
17.2.2 ☐Abnormal
17.2.3 ☐Examination not performed

18. **Examination of the Heart**

18.1 Heart murmur heard	☐No	☐Yes
18.2 Review next clinic	☐No	☐Yes

19. **Condition of the Skin** *(tick at least one)*

19.1 ☐Normal	19.6 ☐Insect bites
19.2 ☐Impetigo	19.7 ☐Boils
19.3 ☐Tinea	19.8 ☐Cellulitis
19.4 ☐Scabies	19.9 ☐Other, *(Specify)*_____
19.5 ☐Eczema	

20. **Blood test results**

☐No ☐**Yes** (**If Yes** write the scores of the test results received)

Test	Score/result	Abnormal	
20.1 Hb	_____	☐No ☐Yes	
20.2 Iron	_____	☐No ☐Yes	
20.3 Ferritin*	_____	☐No ☐Yes	
20.4 RDW*	_____	☐No ☐Yes	
20.5 CRP	_____	☐No ☐Yes	
20.6 Vitamin D	_____	☐Normal	50-160 nmol/L
		☐Insufficient	25-50 nmol/L.
		☐Deficient	<25 nmol/L.

*NB:
- o Abnormal RDW: very likely iron deficiency
- o Low Ferritin/normal RDW: very likely iron deficiency
- o Normal/elevated Ferritin/normal RDW: uncertain of iron status
- o Very high Ferritin/normal RDW: unlikely to be iron deficient

21. **Further Action for blood tests**

21.1 Follow up with patients GP	☐Yes	☐No
21.2 Review at next clinic	☐Yes	☐No
21.3 ☐Other, *(Specify)*_____	_____	_____
_____	_____	_____

22. **Investigations – For follow up**

22.1 ☐Not required
22.2 ☐Delay until child well
22.3 ☐Consent not given
22.4 ☐Iron Studies (green) including Ferritin and CRP*
22.5 ☐Vitamin D* (red)
22.6 ☐FBC (purple)
22.7 ☐Other *(Specify)*_____ * Fill these bottles first

23. **Summary/Plan:**

24. Clinical Assessment completed by _____ *(Initial)*

25. **Intervention Assessment this visit**

	To be completed by GP/ Nurse Practitioner **Intervention/ Treatment required**	To be completed by Nurse **Additional visit or follow up needed prior to next scheduled visit?**
25.1 Respiratory	☐No ☐Yes	☐No ☐Yes
25.2 Nutrition	☐No ☐Yes	☐No ☐Yes
25.3 Oral Health	☐No ☐Yes	☐No ☐Yes
25.4 Hearing	☐No ☐Yes	☐No ☐Yes
25.5 Skin	☐No ☐Yes	☐No ☐Yes
25.6 Immunisation	☐No ☐Yes	☐No ☐Yes
25.7 Smoking Cessation	☐No ☐Yes	☐No ☐Yes
25.8 Housing	☐No ☐Yes	☐No ☐Yes
25.9 Social	☐No ☐Yes	☐No ☐Yes
25.10 Other *(Specify)* _____	☐No ☐Yes	☐No ☐Yes

26. Follow up with; *(tick at least one)*

- ☐ N/A
- ☐ Community Health Worker
- ☐ Primary Care Clinic Doctor/Nurse Practitioner
- ☐ Study Community Clinic Nurse
- ☐ Patients GP
- ☐ Referral to Secondary/Tertiary Clinic

*Reason for follow up:*_____

_____

_____

_____

_____

Date: _____ Time: _____ or ☐ To be arranged

Food Frequency Questionnaire

ID #: | | | | | | | Name Code: | | | | | Visit: | | Date of Assessment: | | / | | / | | | | | Evaluator # | | |

Respondent's relationship to study child (Use relationship codes):

A. Breads and Cereals (ALL questions refer to THIS LAST MONTH)
How often does your child eat the following types of foods?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Breakfast cereal including standard weetbix, cornflakes	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Sweetened breakfast cereal such as Froot Loops or Coco-pops	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Weetbix Hi-Bran or multigrain	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Muesli	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Porridge	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
White bread	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Mixed grain breads	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Maori Bread	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Brown Rice	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
White Rice	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Pasta / noodles	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Fruit bread	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Pitta/naan/wraps	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Other e.g., breakfast muffins	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Food Frequency Questionnaire

ID #: | Name Code: | Visit: | Date of Assessment: / / | Evaluator #

B. Dairy (ALL questions refer to THIS LAST MONTH)

How often does your child eat the following types of foods or drinks?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Milk as a drink	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Trim milk (green, yellow, purple)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Light blue milk	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Other milk (dark blue, full cream)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Milk shakes or flavoured milk drinks	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Milk on cereals	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Ice Cream	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Yoghurt / Dairy Dessert	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Cheese	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Butter	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Margarine	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Blended Preparation	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Food Frequency Questionnaire

ID #: | Name Code: | Visit: | Date of Assessment: / / | Evaluator #

C. Drinks (ALL questions refer to THIS LAST MONTH)

How often does your child have the following types of drinks?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Coffee	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Tea	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Soft drinks (e.g. Coca Cola, Fanta)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Soft drinks lite or sugar free	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Fruit flavoured drinks and cordials	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Fruit juice (reconstituted or freshly squeezed eg. Charlies, Raro, Keri, fruit smoothies)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Vegetable juice (eg. Tomato, carrot)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Water	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Food Frequency Questionnaire

ID #: | Name Code: | Visit: | Date of Assessment: / / | Evaluator #

D. Eggs and Meat (ALL questions refer to THIS LAST MONTH)
How often does your child eat the following types of foods or drinks?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Eggs	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Beef/Pork/Lamb as main dish eg. Steak, chops, roast	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Meat casseroles or dishes Beef/Pork/Lamb; include curries and mince in bolognaise, lasagne etc	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Chicken as main dish	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Poultry as part of dish e.g. Chicken /turkey stir fried	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Chicken/turkey in breadcrumb/batter includes processed chicken bits	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Bacon / Ham	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Processed meats eg. Luncheon, salami	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Meat Pies	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Sausage Rolls	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Liver	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Hamburger	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Corn Beef (canned)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Canned tuna in oil	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Dark Fish (Salmon, sardines, fresh or tinned in brine/water)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Tinned salmon or sardines in oil	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Other canned fish	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Fish fillets (fresh or frozen, with or without crumbs)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Mussels, Pipis, Prawns etc.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Baked beans	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Food Frequency Questionnaire

ID #: | | | | | | | Name Code: | | | | | Visit: | | Date of Assessment: | | / | | / | | | | | Evaluator # | | |

E. Fruit (ALL questions refer to THIS LAST MONTH)
How often does your child eat the following types of foods?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Avocados	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Bananas	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Apples / Pears	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Oranges	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Berries (frozen or fresh)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Stone fruit (fresh apricots, plum, peach)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Kiwifruit	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Pineapple	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Coconut	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Mangoes , Papayas	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Grapes	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Feijoas	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Canned fruit with syrup	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Canned fruit with juice	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Dried fruit	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Food Frequency Questionnaire

ID #: | Name Code: | Visit: | Date of Assessment: / / | Evaluator #

F. Vegetables (ALL questions refer to THIS LAST MONTH)
How often does your child eat the following types of foods?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Tomatoes	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Avocado	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Cucumber	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Sweet corn	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Beans (fresh or frozen but not baked)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Broccoli	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Cauliflower	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Brussels sprouts	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Carrots	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Peas	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Mixed vegetables	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Potatoes / taro steamed or boiled	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Potatoes / taro roasted	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Hot potato fries / chips	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Kumera / pumpkin steamed or boiled	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Kumera / pumpkin roasted	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Spinach or silverbeet	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Other green leafy vegetables (e.g. puha, taro leafs, lettuce)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Celery	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Peppers (all colours)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Food Frequency Questionnaire

ID #: | Name Code: | Visit: | Date of Assessment: / / | Evaluator #

G. Non Dairy (ALL questions refer to THIS LAST MONTH)

How often does your child eat the following types of foods or drinks?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Soya milk as a drink	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Rice milk as a drink	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Other type as drink	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Non milk shakes or flavoured milk substitute drinks	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Milk substitute on Cereals	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Non dairy desserts e.g. soy	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

H. Nuts and Vitamins (ALL questions refer to THIS LAST MONTH)

How often does your child eat the following types of foods or drinks?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
General Multi-vitamins	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Vitamin C	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Iron Supplement	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Fish / Cod Liver Oil	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Other Vitamins or supplements	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Herbal Supplements	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

Food Frequency Questionnaire

ID #: | | | | | | | Name Code: | | | | | Visit: | | Date of Assessment: | | / | | / | | | | | Evaluator # | | |

I. Sweets, Snacks and Spreads (ALL questions refer to THIS LAST MONTH)
How often does your child eat the following types of foods?

	Never	*Less than once per month*	*1-3 times per month*	*1 time per week*	*2-4 times per week*	*5-6 times per week*	*Once per day*	*2 or more times per day*
Potato or other chips / crisps	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Popcorn	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Lollies / sweets	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Chocolate	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Candy bars	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Muesli bars	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Ice blocks	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Chocolate covered and cream filled cookies / biscuits	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Semi-sweet cookies / biscuits	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Crackers / crispbreads	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Bought cakes / muffins	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Pastries	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Home-made cakes / muffins	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Nutella	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Peanut butter	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Jam / honey	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Marmite &vegemite	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Mayonnaise or salad dressing	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8
Tomato sauce/ketchup	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8

1) What type of oil or fat do you regularly use for cooking? By cooking we mean frying and baking. You can tick more than one.
   - ☐ Sunflower oil
   - ☐ Soybean oil
   - ☐ Olive oil
   - ☐ Corn oil
   - ☐ Safflower oil
   - ☐ Butter
   - ☐ Margarine
   - ☐ Linseed oil
   - ☐ Canola oil
   - ☐ Lard
   - ☐ Ghee
   - ☐ Other

     Please describe: _____

2) What type of spread (butter or margarine/blend) does your child eat most often?
   - ☐ Butter
   - ☐ Margarine
   - ☐ Blended type
   - ☐ None

     Which brand do you usually use? _____

Guideline

Follow-up Clinic Visits

Date of Clinic: Insert the date the child actually attended the clinic (not the booked appointment date). All follow up clinic visits are ideally 14 weeks after the last clinic visit.

1. The parental details should be confirmed at every clinic visit to ensure we maintain the most up to date records in case the contact details change. Record and date any changes on the patients' *contacts sheet*.

1.1 Record the relationship of the person who brought the enrolled child to the clinic appointment, if it is someone other than the parent/legal guardian add their name and contact details to the existing contact sheet.

Parental Questionnaire

The parent/person bringing the child to the clinic should answer the following questions. Where it is not the parent and they are unable to provide answers, where possible, make phone contact with the main carer to ascertain correct information.

2. This question ascertains if the child has recovered i.e. no ongoing cough or wheeze from when we recruited them into the study (i.e hospital admission).

2.1 Record if the caregiver thinks the cough was dry or wet, if they do not know tick unsure.
2.2 Refer to the electronic training file for wheeze sounds. You may have to explain what wheeze is, use terms such as *'whistling', 'crackling', 'noisy,' 'squeaky' 'rasping' sounding breathing*.

3. Ask each of these questions individually as stated on the case report form. The question intends to identify any new infections since last clinic visit. A new illness refers to the child being well for 7 consecutive days before becoming ill again.

3.1-3.1.1 Cough: Has the child developed a new cough since last clinic visit and if so describe the nature of the cough.
3.2 Wheeze: Has the child developed any new wheezing.
3.3 Lower respiratory infection: bronchiolitis or pneumonia, parents may describe this as coughing, wheezing, fast or noisy breathing.
3.4 Upper respiratory infection: Croup, pharyngitis, red throat, enlarged tonsils, runny nose, sinus infection, whooping cough, viral infection affecting upper airway.
3.5 Ear infection: otitis media, otitis externa, exudate coming from the ears.
3.6 Skin infections: scabies, infected bites, infected eczema, tinea, boils.
3.7 Gastroenteritis: vomiting and/or diarrhoea for > 24 hours
3.8 Fever unknown cause: defined as parental reporting the child feeling hot to touch with lethargy, and/or a recorded temperature > 38°C with no consistent symptoms of illness lasting for > 24 hours.
3.9 Other: list any other reported illnesses since hospital discharge.

4. List if the child has received or has been prescribed antibiotics since their last scheduled 3monthly clinic visit.

5. List any health professionals the child has visited since the last clinic visit, GP includes their regular GP, community based after hour's accident and medical centre, or a casual visit to another GP. Specify the date or if the parent is unsure provide an estimated date.

6.-6.1 Immunisations
Please update the immunisation schedule in the child's notes to indicate which of the scheduled immunisations were administered at what age. The schedule is indicated by the asterisk (*) of what they should have received at each age group. Indicate if there were any delays greater than four weeks in receiving the immunisations when confirming the immunisation status with the parent/legal guardian.

Other immunisations: There are some immunisations available in New Zealand that are not part of the routine schedule please list if the child received any additional immunisations e.g. Varicella (chicken pox), influenza.

7. Oral Health: if the child is too young (teeth can start showing from 4 months of age) and does not have any teeth indicate 'no' and go to question 8.

7.1 Check if the child has ever had a dental review since the last clinic visit (including Plunket Nurse, Community Dentist and school dental services etc).

7.1.2 Record the outcome of the dental review by asking if any caries were identified i.e. any fillings or teeth extractions required.

8. Nutrition

8.1 Breast milk fed includes both breastfed and fed expressed breast milk. Record if the child is still receiving breast milk

8.1.1 List what age (whole months) they stopped receiving breast milk. Anything < 3 weeks is 0 months and anything ≥ 3 weeks can be rounded up to one month.
8.1.2 List the age (whole months) when the child stopped receiving exclusive breast milk. Or tick N/A if they were never exclusively breast fed. Anything < 3 weeks is 0 months and anything ≥ 3 weeks can be rounded up to one month.

Note: Exclusive = without additional other milk/formula. A child receiving solid foods but not any other form of milk/additional formula is still considered exclusive breast feeding.

9. Smoking: This question ascertains if additional people have moved into where the family reside. Complete this even if previously the child was not smoke exposed.

10. Housing: Has the house where the child lives (greater than 4 days a week) changed since the last contact? If yes refer to CHW for housing intervention.

Clinical Examination
11. Insert the date the clinical examination was completed.

12. Record the following observations as collected at the clinic visit.

12.1 Temperature in Degrees Celsius (axilla temperature)
12.2 Record respiratory rate for young infants. We recommend recording the respiratory rate for the full minute to ensure accuracy.
12.3 Record heart rate per minute
12.4 Record oxygen saturations on air, tick N/A if this is unable to be collected.

12.5 List the weight in kilograms (kg).
12.6 The patients length/height should be recorded at every clinic visit as part of the assessment of growth and development, record in centimetres.
12.7 Assess if the child has any increased work of breathing.

Work of Breathing	**Mild**	**Moderate**	**Severe**
Respiratory rate	<2 months > 60/min 2-12months 50/min		>70/min
Nasal flare & / or grunting	Absent	Absent	Present
Feeding	Normal	-Less than usual -Frequently stops Quantity > half normal	-Not interested -Choking -Quantity < half normal
Chest wall indrawing	None/mild	Moderate	Severe
Behaviour history	Normal	Irritable	Lethargic
Cyanosis	Absent	Absent	Present

PSNZ, Guideline, Wheeze and chest infection in infants under 1 year, 2005 (http://www.paediatrics.org.nz/files/guidelines/Wheezeendorsed.pdf)

Use of accessory muscles: the child may use the sternomastoid muscle to assist with breathing. In young infants this may lead to head bobbing, this is a sign of severe distress.

13. Examination of Teeth:

13.1 Were the teeth examined at the clinic?

13.1.1 Were any dental caries/decay present?
13.1.2 Were any prior fillings present?

14. The Nurse completing the observations and teeth exam should initial here.

15. Respiratory Examination, After completing the respiratory exam please tick at least one of the boxes indicating your findings:

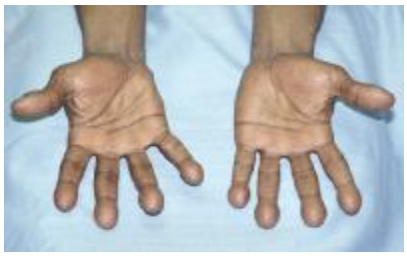
15.1 Normal: indicate if no respiratory distress was seen or anatomical clinical signs of long term respiratory distress noted.
15.2 Stridor: is a gasping sound during inhalation resulting from a partial blockage of the throat (pharynx), voice box (larynx), or windpipe (trachea).
15.3 Wheeze: is a continuous, coarse, whistling sound produced in the respiratory airways during breathing. For wheezes to occur, some part of the respiratory tree must be narrowed or obstructed, or airflow velocity within the respiratory tree must be heightened.
15.4 Crackles: crepitations or rales are heard on auscultation and sound like clicking, rattling, or crackling noises heard during inhalation.
15.5 Other: List any other abnormal respiratory finding.
15.6 Recession: Paediatric patients have a more compliant chest wall (not as rigid as an adults) any increased negative pressures generated in the thorax will result in intercostal, sub-costal or sternal recession. Greater recession = greater respiratory distress.

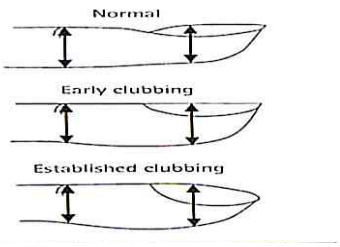
15.7 Chest wall deformity:

- **Harrison's sulcus** is a groove deformity of the lower ribs at the point of attachment to the diaphragm.

- **Pectus carinatumme** also known as “pigeon chest” and is used to describe a chest where the sternum is prominent. It is caused by chronic childhood asthma and rickets.
- **Pectus excavatum:** Significant sternal depression in relation to the mid clavicular rib cage.

15.8 Clubbing (Hippocratic fingers)**:** Bulbous, club like deformation of the distal portion of fingers and toes resulting from connective-tissue proliferation (see below).

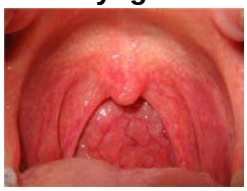




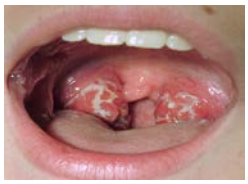
Clubbing, phalangeal depth ratio: Ratio of the distal phalangeal to interphalangeal depth. Clubbing diagnosis: when the distal phalangeal depth > interphalangeal depth (ie, phalangeal depth ratio >1).

15.9 Nasal discharge: mucous-like material that comes out of the nose.

15.10 Pharyngitis: is inflammation of the throat or pharynx.



15.11 Enlarged tonsils (Including tonsillitis):"tonsils" refer to the palatine tonsils. Acute tonsillitis is caused by bacteria and viruses and is accompanied by ear pain when swallowing, bad breath, drooling, sore throat and fever. The tonsil surface may be bright red or have a gray/white coating, while neck lymph nodes may be swollen.



16. Cough during examination: Record if you hear the child cough during your examination period and record the nature of the cough. Refer to cough sounds training for clarification of dry or wet cough.

17. Examination of the ears: Following examination with an otoscope (or auriscope) indicate if your findings for both the right and left ears were normal or abnormal. If abnormal follow the Hearing Intervention form.

Note: An Insufflator should be used in the examination to diagnose effusion.

17.1.3 and 17.2.3 Examination not performed This indicates that the examination was not performed as the child did not tolerate the examination.

18. Examination of the Heart

18.1 Heart murmur: indicate if a heart murmur is heard on auscultation. A murmur is defined as extra heart sounds that are produced as a result of turbulent blood flow that is sufficient to produce audible noise. Further classification is not required.

Note: Innocent heart murmurs; 50% of young children are expected to have an innocent heart murmur. These murmurs are systolic and diminish with sitting and hyperextension of the cervical thoracic spine when sitting (Jordon's maneuver) in the absence of other signs of cardiac pathology.

If a child does not meet the criteria for an innocent heart murmur or you require assistance with cardiac evaluation discuss with the Pediatricians

19. Condition of the skin: Record the results of the skin examination.

19.1 Normal: Tick this option if skin is normal with no inflammation or infection seen.

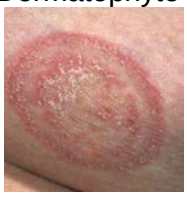
19.2 Impetigo: Primarily caused by *Staphylococcus aureus*, and sometimes by *Streptococcus pyogenes*.

- **Bullous impetigo:** causes painless, fluid-filled blisters usually on trunk, arms and legs. The skin around the blister is usually red and itchy but not sore. The blisters break and scab over with a yellow-colored crust, may be large or small, and may last longer than sores from other types of impetigo.
- **Ecthyma:** is a more serious form of impetigo where infection penetrates deeper into the skin's second layer, the dermis.

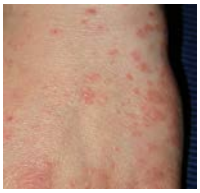
Signs and symptoms include:

- Painful fluid or pus-filled sores that become deep ulcers, usually on legs and feet
- A hard, thick, gray-yellow crust covering the sores
- Swollen lymph glands in the affected area
- Little holes the size of pinheads to pennies appear after crust recedes
- Scars that remain after the ulcers heal

19.3 Tinea: refers to a skin infection with a dermatophyte (ringworm) fungus. Dermatophyte infection is confirmed by microscopy and culture of skin scrapings.



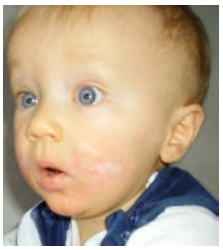
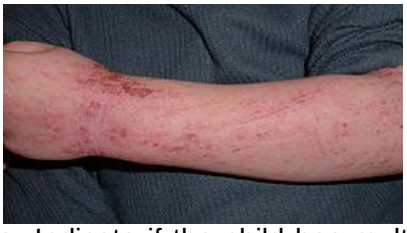
19.4 Scabies: Caused by a tiny parasite *Sarcoptes scabiei* which burrows under the host's skin, causing intense allergic itching. Scabies mites prefer thin hairless skin, and for this reason concentrate on intertriginous parts of the body below the neck (e.g., between fingers and in skin folds), avoiding callused areas. Infants may be infected over any part of the body.



19.5 Eczema, or dermatitis: symptoms vary with all different forms of the condition. They range from skin rashes to bumpy rashes or including blisters. Common signs

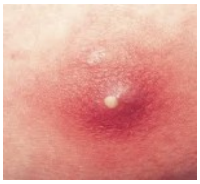
include redness of the skin, swelling, itching and skin lesions and sometimes oozing and scarring.

- **Seborrhoeic dermatitis:** in infants (<3months) is a non-contagious condition of skin areas rich in oil glands (eg, the face, scalp, and upper trunk). Seborrheic dermatitis is marked by overproduction of skin cells (leading to flaking) and sometimes inflammation (leading to redness and itching). It varies in severity from mild dandruff of the scalp to scaly, red patches on the skin.
- **Atopic dermatitis:** is the most common form of dermatitis for children and can affect any part of the body.

19.6 Insect Bites: Indicate if the child has multiple insect bites for example, flea or mosquitoes.

19.7 Boils (or Furuncle): is a deep infective folliculitis (infection of the hair follicle). It is almost always caused by infection by the bacterium *Staphylococcus aureus*, resulting in a painful swollen area on the skin caused by an accumulation of pus and dead tissue.



19.8 Cellulitis: a diffuse inflammation of connective tissue with severe inflammation of dermal and subcutaneous layers of the skin. Cellulitis can be caused by normal skin flora or by exogenous bacteria, and often occurs where the skin has previously been broken: cracks in the skin, cuts, blisters, burns and insect bites.

19.9 Other: Specify any other skin condition that might be affecting the child.

20. Blood test results: Where blood test results are available please complete this section and indicate if the result is normal or abnormal.

21. Further action for blood tests

22. Investigations: Where consent has been given by the parent/legal guardian a blood test should be completed when the child has fully recovered from their respiratory illness. The blood is to taken via Microcollects at the practice, the total volume below of 1450 microlitres is possible. For < 1 year – heel, for 1-5 years – finger. The required tests are;

- **FBC**-250 microlitres PURPLE
- **Iron studies** including **Ferritin** and **CRP** - 600 microlitres (full) GREEN
- **Vitamin D** 600 microlitres RED

Note: If a parent/legal guardian previously refused consent for the blood test but changes their mind, the consent form must be modified prior to the blood test being

obtained. The original consent form needs to be corrected, dated and resigned by the parent/legal guardian, along with your signature and date. Consent form is stored at Kidz First.

23. Summary/Plan
There may be additional information that needs to be recorded. This information will not be collected as study data however will be used by the team to manage any additional relevant information or health related events pertaining to the child and their family/whanau.

24. The person completing the clinical examination and assessment should initial here.

25. Intervention assessment this visit
This table is a final summary of this clinic visit and all of the required interventions. Please tick which of the listed interventions are required and tick Yes or No if treatment requires an additional visit or follow up prior to the next scheduled visit.

Note: Respiratory intervention is compulsory for every child at every visit.

26. Additional follow up
This is to indicate if additional follow up is required for any of the interventions **prior** to the next clinic visit. Indicate who is required to complete the additional follow up and the reason for the additional follow up. Enter a date and time that suits the family for follow up with them.

Guideline for when to attempt to re-book DNA appointments

1. Urgency grading criteria for all <u>first clinic visits</u> where DNA has occurred:

If the child has any of the following they should be booked in to the following weeks clinic (i.e as soon as possible within 2 weeks):
Their enrolment admission they had the following:

- Pneumonia - clinical or radiological
- Bronchiolitis with an ICU/PICU admission and/or
- Consolidation on CXRA and/or
- Recent hospital presentation meeting the above criteria.

If the child meets the following criteria they can wait for the next available clinic appointment (non urgent- to be seen within 1 month).
Their enrolment admission they had the following:

- Bronchiolitis

2. Urgency grading criteria <u>for all other clinic visits</u> where DNA has occurred:

If the child has any of the following they should be booked in to the following weeks clinic (i.e as soon as possible within 2 weeks):
A recent hospital admission with any of the following:

- Pneumonia - clinical or radiological
- Bronchiolitis with an ICU/PICU admission and/or
- Consolidation on CXRA and/or
- The caregiver is reporting the child has a wet cough or any other LRI symptoms

If the child meets the following criteria they can wait for the next available clinic appointment (non urgent- to be seen within 1 month).

- No hospital presentations or admissions for LRI
- No wet cough or LRI symptoms

Guideline for booking clinic appointments- delays between clinics

Patients are to have **at least 1** month between clinics with **no more** than **4** months between clinics

- If a patients next clinic visit falls exactly one month after their most recent visit consider if they are;
  - Well
  - The family situation
  - GP's and Nurse Practitioners opinion

  The next visit can either be scheduled for one month's time or delayed for 4 months.

- Antibiotic F/up's if required should still be held either 1-2 or 3-4 weeks after their initial clinic appointment.
- Patients attending an AB f/up **1+** months after their previous clinic can have their scheduled clinic visit combined with their AB f/up
- Patients attending an AB f/up whose last clinic visit is **within** a month do not need to have the next clinic visit forms included in their f/up. The next visit can be scheduled for within the next 4 months.

Examples:

Enrolment discharge	**Attends CV1**	**Scheduled Cv2**	**Scheduled Cv3**	**Result –Next clinic**
01/01/12	15/04/12	15/05/12	30/08/12	Either Cv2 or Cv3
01/03/12	01/07/12	~~15/07/12~~	01/11/12	Cv3
01/04/12	01/07/12	15/08/12	01/12/12	Cv2

Summary –This page is to be completed by the Kidz First research team prior to the child attending clinic 8

Children are to be seen within 2 years 3 months where possible as agreed at investigator meeting 16th May 2013. Acutely unwell (Tachypnoea and or fever –WHO definition) children are to be deferred to a later clinic (30 days).

Services Under: Paediatric Respiratory at Starship-**excluded**
Current services: All general and other subspecialty paeds, Allied Health and nursing
Services previously involved: Paed/Subspecialty Paed only

Immunisations: The National Immunisation Register is to be checked for the child's immunisation status. If the child's immunisations are not up to date it will be documented if they have no immunisations or if the child is overdue for their next immunisation. An separate immunisation table will be provided with details of the immunisations and dates of immunisation.

EC presentations since enrolment: This is presentations to Emergency Care as recorded on concerto including Starship and Waikato Hospitals.

Hospital re-admissions since enrolment: This is admissions to a hospital ward as recorded on concerto - including Starship/Waitemata)

Respiratory admissions since enrolment: This is based on the first diagnosis on discharge letter. Including; Bronchiolitis, Pneumonia, Pleural effusion, empyema, bronchopneumonia Asthma, Wheezing illness, Croup / laryngotracheobronchitsis URTI/AOM as main diagnosis.

ICU admissions since enrolment: Including admissions to Starship PICU.
Note: count ICU MMH transfer to PICU as one admission.

Antibiotic prescriptions since enrolment: This is ascertained from Concerto prescribing information. Note: Not all pharmacies are reporting on Concerto. Where none or partial prescribing information is available please document what area the patient lives in and the date of the period of no information.

NOTE: When interviewing the family use the child's name where possible (…..) is placed throughout the CRF as prompts to use the child's name.

<u>Nurse Section:</u>
Medications list
Ask the parent/caregiver what medications the child is currently taking, record all medications listed by the parent/caregiver.
(the following terms may be described by parents/caregivers)

- Paracetamol other names include pamol, parapaed, paracare, acetaminophen,
- Blue inhaler is referring to any inhaler that is a bronchodilator such as ventolin, salbutamol, respigen.
- Other inhalers this may include preventer inhalers such as flixotide.
- Oral steroids, this may include redipred, predisolone
- Antiobiotics examples may include; amoxycillin, Amoxycillin and clavulanic acid, penicillin, erythromycin, flucloxicillin.

1. Indicate who is present when you are completing the questionnaire, tick as many boxes as required. This only refers to adults/caregivers not to siblings.

2. Please list all languages that the parent identifies are spoken at home i.e. Samoan and English. This <u>does not</u> refer to what languages the child can speak.

3. Which one of the terms describes the child's health best.

4.1 Ask the parent/caregiver if the child has any siblings, this includes half brothers and sisters.

4.2 Ask the parent/caregiver if the child attends any form of daycare/kindergarten – tick all that apply.

4.3 This refers to all children who currently reside in the house attend a day care including the following: registered daycare, care and/or kindergarten, playcentre, PORSE, Pacific language nest, To Kohanga Reo or equivalent.

4.4 This question is to assess the ability of the main carer to access healthcare when required and in addition will also enable the CHW's to assess ability to follow up the family. Do they have access to a car between the hours of 9am-5pm.

4.5 This included full or part time work and short term contract work.

NOTE: Where parents share custody of a child document the family situation for where the child spends most of their time. If the child spends equal amount of their time at two different homes record two sets of data for each home on the CRF. When entering the information in the database enter the 'worst' exposure this child has.

5. The smoking question relates to any smoke exposure, including people that smoke outside.
5.1-5.2 Select immediate family who smoke.

5.3 Ask the parent/caregiver if there is any other person living in the house at the current time who smokes cigarettes (this includes smoking inside and outside the home).

5.4 Write the total number of smokers living in the same house as the child.

6.1 Ask the parent/caregiver "*if they have heard of bronchiectasis",* if they have not heard of it, it is likely that no relatives of the child have it.

6.2 Chronic wet cough refers to the child coughing everyday and sounding as though they could bring up or actually do bring up mucus or phlegm / gunk.

6.3-6.6 Confirm history of Asthma or Allergies and Tuberculosis in only the listed family members this does not include the extended family.

7. Observations: Record the following observations as collected at the clinic visit.

7.1 Temperature in degrees celsius (tympanic membrane thermometer)

7.2 Record the respiratory rate for the full minute to ensure accuracy.

7.3 Record heart rate per minute

7.4 Record oxygen saturations on air, tick N/A if this is unable to be collected. Document the highest level recorded, 98-99% is normal. If the score is 96% or below re-test.

7.5 List the weight in kilograms (kg). Patients are to be weighed without their shoes/any heavy jackets.

7.6 The patients length/height should be recorded as part of the assessment of growth and development, record in centimetres. Make sure the child is not wearing shoes when height is measured.

7.7 Assess if the child has any increased work of breathing.

Work of Breathing	**Mild**	**Moderate**	**Severe**
Respiratory rate	normal	>40/min	>50/min
Nasal flare & / or grunting	Absent	Absent	Present
Feeding	Normal	-Less than usual -Frequently stops -Quantity > half normal	-Not interested -Choking -Quantity < half normal
Chest wall indrawing	None/mild	Moderate	Severe
Behaviour history	Normal	Irritable	Lethargic
Cyanosis	Absent	Absent	Present

PSNZ, Guideline, Management of Asthma in Children aged 1-15 years 2005

8. Record if you hear the child cough during your examination period and record the nature of the cough.

The Nurse completing the observations and initial questionnaire should initial here.

Doctor Section:

9. List any concerns the parent/caregiver has regarding the child's health.

9.1 You may have to explain what wheeze is for parents. To explain this to parents you can use terms such as *'whistling', 'crackling', 'noisy,' 'squeaky' 'rasping' sounding breathing*.

9.2 Does the parent/caregiver think the child is similar in size to their other children at the same age.

9.3 Does the parent/caregiver think that the child can not hear them properly.

9.4 Ear infection as diagnosed by a health professional and/or had a definite sign of ear infection such as exudate coming from the ears.

9.5 Has the child been diagnosed with developmental delay or does the parent have concerns around the child's ability to walk/talk.

9.6 Do the parents/caregiver have any concerns around the child's behaviour that they think is abnormal.

9.7 Has a doctor told the parent/caregiver that the child has a cardiac/heart problem.

9.8 Check if the parent has ever been told by a health professional that their child has eczema and/or has persistent itchy skin irritation. The definition of eczema: is a form of dermatitis, or inflammation of the epidermis (the outer layer of the skin).

9.9 An allergy of any kind can be included here this may be parental impression or medically diagnosed and may include; a medication allergy, food allergy, hay fever,

bee stings, atopic allergy, common allergens other than food may include grass, dust, animals, pollens.

9.10 Write any other concerns the parent/caregiver has about their child.

10. How does the parent/caregiver rate the child's health in comparison with their other children (select N/A if only child).

11. Ask if any siblings have been admitted to hospital under the age of 15 for a full night or longer.

12. Record if any of the child's siblings have a problem with coughing
12.1 Record if the caregiver thinks the cough was dry or wet, if they do not know tick unsure.

13.1 Has the child ever had a mucusy/fruity/phlegmy wet cough.

13.2 Record if the parent/caregiver thinks that over the last 12months the child has coughed most days. NB: This is more than normal children without a recent cold may cough between 1-34 times a day, however, a chronic cough of 3 weeks or longer is unusual. Daily cough for greater than 4-6 weeks may mean there is an underlying disease. (*SSH Guideline 2008 COUGH – INVESTIGATION OF CHRONIC COUGH &/OR CONFIRMED BRONCHIECTASIS)*

13.3 This refers to a persistent everyday occurring cough that did not get better and go away for at least 8 weeks in the last year. Record if the caregiver thinks the cough was dry or wet, if they do not know tick unsure.

13.4 This refers to a persistent everyday occurring cough that did not get better and go away for at least 1 month in the last year. Record the number of times the child has had a cough that did not go away for 1 month.

13.5-13.6 Record if the parent/caregiver thinks that the child coughs in the evening/at night and during and after exercise.

13.7-13.8 Record if the parent/caregiver thinks the child currently has a cough and how troublesome they feel the child's cough is (one being no cough and 10 being a very severe cough).

14.1-14.3 You may have to explain what wheeze is for parents. To explain this to parents you can use terms such as *'whistling', 'crackling', 'noisy,' 'squeaky' 'rasping' sounding breathing*.

- Blue inhaler is referring to any inhaler that is a bronchodilator such as ventolin, salbutamol, respigen.
- Other inhalers this may include preventer inhalers such as flixotide.
- Oral steroids, this may include redipred, predisolone

14.4 Doctor diagnosis of asthma only included here, this may be any doctor from a GP, hospital specialist or if after hours clinic tick GP.

14.5 Ask the parent/caregiver if the child snore's at night while sleeping – this is to assess for childhood obstructive sleep apnoea (OSA). Usually parents of children with OSA notice their children have loud snoring, pauses in breathing and difficulty breathing during sleep. Parents may also notice their child chocking, gasping or

snorting while sleeping. Obesity is a common cause of OSA in children. *(RCH OSA Factsheet)*

15. This question is trying to ascertain that the child does not have any reflux symptoms and/or ENT problems that might be resulting in aspiration. This is at any point in the child's life.

16. Respiratory Examination, After completing the respiratory exam please tick at least one of the boxes indicating your findings:

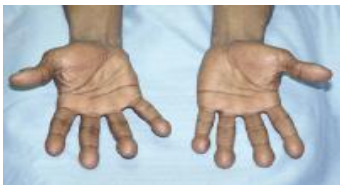
16.1 Normal: indicate if no respiratory distress was seen or anatomical clinical signs of long term respiratory distress noted.

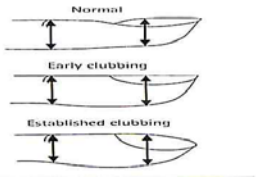
16.2 Stridor: is a gasping sound during inhalation resulting from a partial blockage of the throat (pharynx), voice box (larynx), or windpipe (trachea).

16.3 Wheeze: is a continuous, coarse, whistling sound produced in the respiratory airways during breathing. For wheezes to occur, some part of the respiratory tree must be narrowed or obstructed, or airflow velocity within the respiratory tree must be heightened.

16.4 Crackles: crepitations or rales are heard on auscultation and sound like clicking, rattling, or crackling noises heard during inhalation.

16.5 Clubbing (Hippocratic fingers)**:** Bulbous, club like deformation of the distal portion of fingers and toes resulting from connective-tissue proliferation (see below).





Clubbing, phalangeal depth ratio: Ratio of the distal phalangeal to interphalangeal depth. Clubbing diagnosis: when the distal phalangeal depth > interphalangeal depth (ie, phalangeal depth ratio >1).

16.6 Transmitted Sounds:

16.7 Other: List any other abnormal respiratory finding.

16.7 Recession: Pediatric patients have a more compliant chest wall (not as rigid as an adults) any increased negative pressures generated in the thorax will result in intercostal, sub-costal or sternal recession. Greater recession = greater respiratory distress.

16.8 Chest wall deformity:

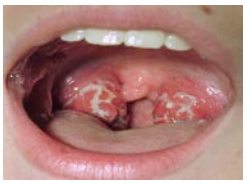
- **Harrison's sulcus** is a groove deformity of the lower ribs at the point of attachment to the diaphragm.
- **Pectus carinatumme** also known as "pigeon chest" and is used to describe a chest where the sternum is prominent. It is caused by chronic childhood asthma and rickets.
- **Pectus excavatum:** Significant sternal depression in relation to the mid clavicular rib cage.

NOTE: If you have selected any of the above mark the respiratory exam as Abnormal

16.9 Nasal discharge: mucous-like material that comes out of the nose.

16.10 Pharyngitis: is inflammation of the throat or pharynx.

16.11 Enlarged tonsils (Including tonsillitis):"tonsils" refer to the palatine tonsils. Acute tonsillitis is caused by bacteria and viruses and is accompanied by ear pain when swallowing, bad breath, drooling, sore throat and fever. The tonsil surface may be bright red or have a gray/white coating, while neck lymph nodes may be swollen.



17. Cough during examination: Record if you hear the child cough during your examination period and record the nature of the cough.

18. The child is required to run 10m up and down the corridor once – the distance will be marked for consistency. Record if you hear the child cough during the exercise or during your exam post-exercise and record the nature of the cough.

19. Heart murmur: indicate if a heart murmur is heard on auscultation. A murmur is defined as extra heart sounds that are produced as a result of turbulent blood flow that is sufficient to produce audible noise. If you think the murmur is pathological provide additional details.

Note: Innocent heart murmurs; 50% of young children are expected to have an innocent heart murmur. These murmurs are systolic and diminish with sitting and hyperextension of the cervical thoracic spine when sitting (Jordon's maneuver) in the absence of other signs of cardiac pathology.

If a child does not meet the criteria for an innocent heart murmur or you require assistance with cardiac evaluation discuss with the Study Lead Investigators

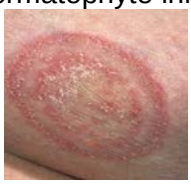
20. Condition of the skin: Record the results of the skin examination.
20.1 Normal: Tick this option if skin is normal with no inflammation or infection seen.

20.2 Impetigo: Primarily caused by *Staphylococcus aureus*, and sometimes by *Streptococcus pyogenes*.

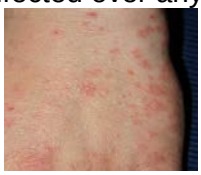
- **Bullous impetigo:** causes painless, fluid-filled blisters usually on trunk, arms and legs. The skin around the blister is usually red and itchy but not sore. The blisters break and scab over with a yellow-colored crust, may be large or small, and may last longer than sores from other types of impetigo.
- **Ecthyma:** is a more serious form of impetigo where infection penetrates deeper into the skin's second layer, the dermis.

- **Signs and symptoms include:**
- Painful fluid or pus-filled sores that become deep ulcers, usually on legs and feet
- A hard, thick, gray-yellow crust covering the sores
- Swollen lymph glands in the affected area
- Little holes the size of pinheads to pennies appear after crust recedes
- Scars that remain after the ulcers heal

20.3 Tinea: refers to a skin infection with a dermatophyte (ringworm) fungus. Dermatophyte infection is confirmed by microscopy and culture of skin scrapings.

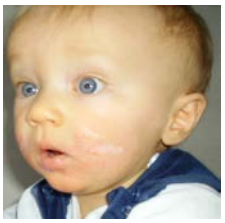


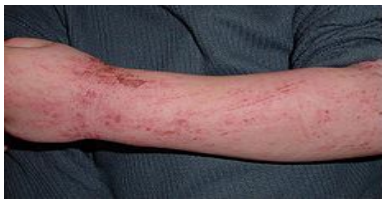
20.4 Scabies: Caused by a tiny parasite *Sarcoptes scabiei* which burrows under the host's skin, causing intense allergic itching. Scabies mites prefer thin hairless skin, and for this reason concentrate on intertriginous parts of the body below the neck (e.g., between fingers and in skin folds), avoiding callused areas. Infants may be infected over any part of the body.



20.5 Eczema, or dermatitis: symptoms vary with all different forms of the condition. They range from skin rashes to bumpy rashes or including blisters. Common signs include redness of the skin, swelling, itching and skin lesions and sometimes oozing and scarring.

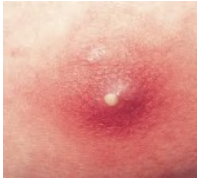
- **Seborrhoeic dermatitis:** in infants (<3months) is a non-contagious condition of skin areas rich in oil glands (eg, the face, scalp, and upper trunk). Seborrheic dermatitis is marked by overproduction of skin cells (leading to flaking) and sometimes inflammation (leading to redness and itching). It varies in severity from mild dandruff of the scalp to scaly, red patches on the skin.
- **Atopic dermatitis:** is the most common form of dermatitis for children and can affect any part of the body.





22.6 Insect Bites: Indicate if the child has multiple insect bites for example, flea or mosquitoes.

22.7 Boils (or Furuncle): is a deep infective folliculitis (infection of the hair follicle). It is almost always caused by infection by the bacterium *Staphylococcus aureus*, resulting in a painful swollen area on the skin caused by an accumulation of pus and dead tissue.



20.8 Cellulitis: a diffuse inflammation of connective tissue with severe inflammation of dermal and subcutaneous layers of the skin. Cellulitis can be caused by normal skin flora or by exogenous bacteria, and often occurs where the skin has previously been broken: cracks in the skin, cuts, blisters, burns and insect bites.
20.9 Other: Specify any other skin condition that might be affecting the child.

21.1 Were the teeth examined at the clinic?
21.1.2 Were any dental caries/decay present?
21.1.3- 4 Were any prior fillings or extractions present?
21.1.5 Does the child have gingivitis?

22. Examination of the ears: Following examination with an otoscope (or auriscope) indicate if your findings for both the right and left ears were normal or abnormal. If abnormal follow the Hearing Intervention form. **Note:** An Insufflator should be used in the examination to diagnose effusion.

22.1.2 and 20.2.2 Examination not performed This indicates that the examination was not performed as the child did not tolerate the examination

23. Assessment
23.1 Select a likely diagnosis for the child based on your assessment of them in clinic

23.2 Select the child's current respiratory health - you can select more than one.

- **Normal:** Record normal if there are no respiratory symptoms or concerns
- **Wheeze:** is a continuous, coarse, whistling sound produced in the respiratory airways during breathing. For wheezes to occur, some part of the respiratory tree must be narrowed or obstructed, or airflow velocity within the respiratory tree must be heightened.
- **URTI (Upper respiratory infection):** Croup, pharyngitis, red throat, enlarged tonsils, runny nose, sinus infection, whooping cough, viral infection affecting upper airway.
- **LRTI (Lower respiratory infection):** bronchiolitis or pneumonia, parents may describe this as coughing, wheezing, fast or noisy breathing.

23.3 Problem List: Document any problems you identified during your assessment of the child.

24. Investigations: Where consent has been given by the parent/legal guardian a blood test should be completed when the child has fully recovered from their respiratory illness. Parent can also consent to a FBC and Fe studies but refuse to have samples of Vitamin D and IgE taken for storage and later testing.

The blood is to taken via Microcollects at the practice, the total volume below of 1450 microlitres is possible. The required tests are;

- **FBC**-250 microlitres PURPLE
- **Iron studies** including **Ferritin** and **CRP** - 600 microlitres (full) GREEN
- **Vitamin D** 600 microlitres RED
- **IgE**

Note: If a parent/legal guardian previously refused consent for the blood test but changes their mind, the consent form must be modified prior to the blood test being obtained. The original consent form needs to be corrected, dated and resigned by the

parent/legal guardian, along with your signature and date. Consent forms are stored at Kidz First.

25. Recommendations/Referral: This table is a final summary of this clinic visit and all of the required interventions. Please tick which of the listed interventions are required and describe what treatment/referral is required. This will form the basis of the action plan for each child.

26. Document if you have prescribed any medications and what for.

27. Document the ease of communication with the parent/caregiver. This includes Health literacy, understanding and language barriers.

Children with wet cough, crackles and or abnormal CXray as assessed by the clinic Doctor are to be treated with 14 days antibiotics (see antibiotic prescribing protocol).

Children receiving antibiotics are to attend a follow up clinic within 14-21 days post CV8. If the child is still unresponsive following their 2 week course of antibiotics a further extended course is to be prescribed with referral to and follow up from the patients own GP. Patients are to be referred to tertiary care with follow up within 8 weeks.

Referral to tertiary care requires any of:

1. **Wet cough at clinic at a time of stability/wellness (wet cough non responsive to two weeks of antibiotics), AND/OR;**
2. **Crackles or Clubbing on examination AND/OR;**
3. **Abnormal CXR AND/OR;**
4. **Persistent Cough for > 8 weeks in the last 12 months AND/OR;**
5. **Cough > 4 weeks 2 or more times in the last 12 months**

Consent for Referral to the Healthy Housing Programme

Name:_____ **Date:**_____

Address:_____

_____

Contact Telephone Number:_____

What is the Healthy Housing Programme?

The Healthy Housing Programme is a joint initiative between Housing New Zealand Corporation (HNZC) and Counties Manukau District Health Board.

These organisations work together to:

- increase awareness of infectious diseases
- improve your access to health and social services
- reduce the risk of housing-related health problems
- identify overcrowding

What happens if I agree to take part in the Healthy Housing Programme?

The Healthy Housing Project Manager from HNZC and a Public Health Nurse from the Counties Manukau District Health Board will visit your home. They will ask you questions, collect information, and discuss with you and your household's your health and housing needs.

Participation in the Healthy Housing Programme is voluntary and you can withdraw by telling the Healthy Lungs Community Health Worker you do not wish to proceed with the referral to the Healthy Housing Programme.

I consent for the Healthy Lungs Community Health Worker to refer both myself and my family/whanau to the Healthy Housing Programme.

Signature: _____

Housing

Housing type	☐Housing New Zealand ☐Private rental ☐Your own home ☐Temporary accommodation ☐Other:*(Specify)* _____

1. Family consented to housing assessment ☐Yes (Continue) ☐No *(stop here)*
2. Where does your child sleep?
   ☐Lounge
   ☐Own bedroom
   ☐Shared bedroom with parent/adult
   ☐Shared bedroom with sibling
   ☐Other (*Specify)*_____
3. What does your child sleep in/on?

Cot	☐Yes	☐No
Bed	☐Yes	☐No
Mattress	☐Yes	☐No

   Other *(Specify)* _____
4. Does the room where your child sleeps have the following?

Curtains	☐Yes	☐No
Carpet	☐Yes	☐No

5. Is your child's room mouldy? ☐Yes ☐No
   If **Yes,**
   ☐Extensive Blackened area
   ☐Large patches
   ☐Moderate patches
   ☐Specks of mould
6. Does your house have working electricity? ☐Yes ☐No
7. Does your house have running water? ☐Yes ☐No ☐Dripping only
8. Working utilities:

Washing machine	☐Yes	☐No	Heating	☐**Yes** ☐No
Washing Line/dryer	☐Yes	☐No	**If Yes,** heating type	☐Electricity
Fridge	☐Yes	☐No		☐Mains gas (at street)
Freezer	☐Yes	☐No		☐Bottled gas (unflued gas heater)
Toilet	☐Yes	☐No		☐Wood
Stove	☐Yes	☐No		☐Coal
Oven	☐Yes	☐No		☐Solar heating system
Microwave	☐Yes	☐No		☐Other fuel (s)*(Specify)*_____
Hot water	☐Yes	☐No		

9. Does the family qualify for housing assistance? ☐Yes ☐No
   9.1 **If Yes,** consent to housing referral ☐**Yes** ☐No *(go to question 9.2)*
   9.1.1 **If Yes,** Referral made ☐Yes ☐**No**
   9.2 **If No,** letter to be sent to landlord ☐Yes ☐No

Issues:

Summary:

Damp/Mouldy	☐Low Risk	☐Medium Risk	☐High Risk
State of repair	☐Low Risk	☐Medium Risk	☐High Risk
Hygiene	☐Low Risk	☐Medium Risk	☐High Risk

Healthy Housing Applicant Details – Healthy Lungs Study	
Name:	S/W#:
Address:	
Ph #'s:	
Priority: High / Medium / Low	House Insulated: Yes / No
Consent Obtained: Yes / No	CSC: Yes / No
Assessment Date:	
Information for visiting providers (risks / cultural considerations etc):	

Number of Bedrooms	☐1 ☐2 ☐3 ☐4 ☐5 ☐more_____	
Occupants		
Bedroom 1	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 2	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 3	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 4	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 5	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Other room i.e. Lounge	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Total adults:_____(15 years and over) Total children:_____		

Housing- Clinic 8

Housing type	
☐Owned by myself or family trust	☐Owned by another person living in the house
☐Rented from family	☐Rented from Housing New Zealand
☐Rented from Council	☐Temporary accommodation
☐Rented from private landlord	☐Other:*(Specify)* _____

1. Family consented to housing assessment ☐Yes (Continue) ☐No *(stop here)*
2. Where does your child sleep?
   - ☐Lounge
   - ☐Own bedroom
   - ☐Shared bedroom with parent/adult
   - ☐Shared bedroom with sibling
   - ☐Other (*Specify)*_____
3. What does your child sleep in/on?

Cot	☐Yes	☐No
Bed	☐Yes	☐No
Mattress on the floor	☐Yes	☐No

   Other *(Specify)* _____
4. Does the room where your child sleeps have the following?

Curtains	☐Yes	☐No
Carpet	☐Yes	☐No

5. Is your child's room mouldy? ☐Yes ☐No
   If **Yes,**
   - ☐Extensive Blackened area
   - ☐Large patches
   - ☐Moderate patches
   - ☐Specks of mould
6. Does your house have working electricity? ☐Yes ☐No
7. Does your house have running water? ☐Yes ☐No ☐Dripping only
8. Working utilities:

Washing machine	☐Yes	☐No	Heating	☐**Yes** ☐No
Washing Line/dryer	☐Yes	☐No	**If Yes,** heating type	☐Electricity
Fridge	☐Yes	☐No		☐Mains gas (at street)
Freezer	☐Yes	☐No		☐Bottled gas (unflued gas heater)
Toilet	☐Yes	☐No		☐Wood
Stove	☐Yes	☐No		☐Coal
Oven	☐Yes	☐No		☐Solar heating system
Microwave	☐Yes	☐No		☐Other fuel (s)*(Specify)*_____
Hot water	☐Yes	☐No		

9. Does the family qualify for housing assistance? ☐Yes ☐No
   - 9.1 **If Yes,** consent to housing referral ☐**Yes** ☐No *(go to question 9.2)*
     - 9.1.1 **If Yes,** Referral made ☐Yes ☐**No**
   - 9.2 **If No,** letter to be sent to landlord ☐Yes ☐No
10. Is your home usually colder than you would like? ☐Yes ☐No
11. During the last month, has your house ever felt so cold that you have shivered inside?" ☐Yes ☐No
12. Does your home smell mouldy or musty? ☐Yes ☐No
13. Is there mould on the walls or ceilings in bedrooms or living areas of your home?" ☐Yes ☐No
14. Are there damp walls or ceilings in the bedrooms or living areas of your home?" ☐Yes ☐No
15. Does your *home* have insulation *(like Pink Batts)* ☐Yes ☐No

16. How many rooms *are there in your child's home*? *(Do not count bathrooms, showers, toilets, laundries, halls, garages, and pantries)*
Count; Count open-plan rooms such as kitchen-lounge-dining as three rooms

	Bedrooms.
	Kitchens.
	Dining rooms.
	Lounges or living rooms.
	Rumpus rooms, family rooms etc
	Conservatories/Sun room you can sit in.
	Studies, studios, hobby rooms etc.
	Total

Occupants		
Bedroom 1	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 2	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 3	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 4	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Bedroom 5	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Other room i.e. Lounge	☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female ☐Male ☐Female	DoB: _____ DoB: _____ DoB: _____ DoB: _____ DoB: _____
Total adults:_____(15 years and over) Total children:_____		

Issues:

Summary:

Damp/Mouldy	☐Low Risk	☐Medium Risk	☐High Risk
State of repair	☐Low Risk	☐Medium Risk	☐High Risk
Hygiene	☐Low Risk	☐Medium Risk	☐High Risk

Nutrition Questionnaire < 6 months

1. What kinds of milk other than breast milk have you given your baby? ☐N/A
   - Standard infant formula ☐Yes ☐No
   - Standard follow on formula ☐Yes ☐No
   - Cow's milk ☐Yes ☐No
   - Soya formula ☐Yes ☐No
   - Goats milk formula ☐Yes ☐No
   - Other (Specify)_____ ☐Yes ☐No

2. How old was your child when s/he started first drinking milk formula? ☐N/A
   Age_____months

3. How old was your child when s/he stopped breast feeding? ☐N/A
   Age_____months

4. How old was your child when s/he stopped having any infant formula or follow-on formula even at bed time? ☐N/A
   Age_____months

5. How old was your child when s/he first started taking cows milk as a drink? ☐N/A
   Age_____months

6. How old was your child when s/he first ate solid food on a daily basis? ☐N/A
   Age_____months
   6.1. What type of food did s/he first eat? ☐N/A
   - Commercials (in tins and jars) ☐Yes ☐No
   - Homemade ☐Yes ☐No

7. Does your child ever have;
   - Fruit juice ☐Yes ☐No
   - Fast food/takeaway ☐Yes ☐No
   - Energy drinks ☐Yes ☐No
   - Soft drinks ☐Yes ☐No
   - Potato chips ☐Yes ☐No
   - Tea/milo/coffee ☐Yes ☐No

Summary: Community Health Worker

Overall Evaluation:	**Low Risk**	**Medium Risk**	**High Risk**
Breast feeding			
Use formula if not breast feeding			
Solids near to 6 months			
Junk food			
Total			

Clinic Summary:

Low Risk	**Medium Risk**	**High Risk**
☐Weight 2-98th percentile Height 2-98th with < 2 centile difference	☐Weight 2-98th percentile Height 2-98th with >2 centile difference	☐Weight > 98th centile
☐Healthy	☐Recent illness, surgery or hospitalisation	☐Lengthy illness or medical condition
	☐History of iron deficiency, treated with diet	☐History of iron deficiency anemia, treated with diet and medication
☐No GI problems	☐Chronic GI problems which occur a few times a week	☐Chronic GI problems which occur more than twice a week

Summary: Health Professional Opinion

Low Risk | Medium Risk | High Risk

Nutrition Questionnaire 6-12 months

1. What kinds of milk other than breast milk have you given your baby? ☐N/A
   - Standard infant formula ☐Yes ☐No
   - Standard follow on formula ☐Yes ☐No
   - Cow's milk ☐Yes ☐No
   - Soya formula ☐Yes ☐No
   - Goats milk formula ☐Yes ☐No
   - Other (Specify)_____ ☐Yes ☐No

2. How old was your child when s/he started first drinking a milk formula? ☐N/A
   Age_____months

3. How old was your child when s/he stopped breast feeding? ☐N/A
   Age_____months

4. How old was your child when s/he stopped having any infant formula or follow-on formula even at bed time? ☐N/A
   Age_____months

5. How old was your child when s/he first started taking cows milk as a drink? ☐N/A
   Age_____months

6. How old was your child when s/he first ate solid food on a daily basis? ☐N/A
   Age_____months

   6.1. What type of food did s/he first eat? ☐N/A
   - Commercials (in tins and jars) ☐Yes ☐No
   - Homemade ☐Yes ☐No

7. What other types of drinks did your child drink before turning one;
   - Fruit juices ☐Yes ☐No
   - Fruit drinks ☐Yes ☐No
   - Soft fizzy drinks ☐Yes ☐No
   - Energy drinks ☐Yes ☐No
   - Soya milk ☐Yes ☐No
   - Coffee ☐Yes ☐No
   - Tea ☐Yes ☐No
   - Flavoured milk (Milo, Nesquik, Ovaltine) ☐Yes ☐No

8. How old was your baby when s/he first ate real meat that you prepared yourself (not commercial baby dinners)? ☐N/A
   Age_____months

9. How often does your child eat;
   - Red meat ☐Often ☐Sometimes ☐Rarely ☐Never
   - Chicken ☐Often ☐Sometimes ☐Rarely ☐Never
   - Eggs ☐Often ☐Sometimes ☐Rarely ☐Never
   - Dairy products ☐Often ☐Sometimes ☐Rarely ☐Never
   - Fruit ☐Often ☐Sometimes ☐Rarely ☐Never
   - Vegetables ☐Often ☐Sometimes ☐Rarely ☐Never
   - Pasta/bread/cereal/rice ☐Often ☐Sometimes ☐Rarely ☐Never

10. Did your child take iron supplements when s/he was < 1yr old? ☐Yes ☐No
    10.1 **If Yes,** how many months did your child take iron supplements Age_____months

11. Does your child currently take vitamin or mineral supplements? ☐Yes ☐No
    11.1 **If Yes,** how many months has your child taken vitamin supplements Age_____months

12. To what extent does your child show these behaviours?

- Irritable	☐Often	☐Sometimes	☐Rarely	☐Never
- Picky eater	☐Often	☐Sometimes	☐Rarely	☐Never
- Listless (low energy, lack of interest in food)	☐Often	☐Sometimes	☐Rarely	☐Never
- Tired (falling asleep at meals)	☐Often	☐Sometimes	☐Rarely	☐Never
- Sensitive to cold	☐Often	☐Sometimes	☐Rarely	☐Never
- PICA (eating non-food items i.e. soil, ice)	☐Often	☐Sometimes	☐Rarely	☐Never

13. Do you have any concerns about your child's eating ☐Yes ☐No
13.1 **If Yes,** Describe_____ _____

14. In general how healthy is her/his diet? ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐Don't know

15. Over the last 4 weeks how many hours per day did your child spend outdoors in the sun?
- During the week Average hrs per day_____
- During the weekend (Sat/Sunday) Average hrs per day_____

16. Over the last 4 weeks what time of day is your child usually outside?

- Early morning (7am-11am)	☐Yes	☐No
- Middle of the day (11am-3pm)	☐Yes	☐No
- Afternoon (3pm-7pm)	☐Yes	☐No
- Evening (after 7pm)	☐Yes	☐No

17. Does your child ever have;

- Fast food/takeaway	☐Yes	☐No
- Soft drinks	☐Yes	☐No
- Potato chips	☐Yes	☐No

Summary: Community Health Worker

Overall Evaluation:	**Low Risk**	**Medium Risk**	**High Risk**
Breast feeding			
Use follow-on formula if not breast feeding			
Good mix of solids			
Junk food consumption			
Cows milk consumption			
Total			

Clinic Summary:

Low Risk	**Medium Risk**	**High Risk**
☐Weight 2-98th percentile Height 2-98th with < 2 centile difference	☐Weight 2-98th percentile Height 2-98th with >2 centile difference	☐Weight > 98th centile
☐Healthy	☐Recent illness, surgery or hospitalisation	☐Lengthy illness or medical condition
	☐History of iron deficiency, treated with diet	☐History of iron deficiency anemia, treated with diet and medication
☐No GI problems	☐Chronic GI problems which occur a few times a week	☐Chronic GI problems which occur more than twice a week

Summary: Health Professional Opinion

Low Risk | Medium Risk | High Risk

Nutrition Questionnaire >12 months

1. On average how many servings of fruit does your child eat per day

Includes: fresh, frozen, canned or stewed fruit (doesn't include fruit juice)
One serving = 1 medium piece (i.e. 1 apple) or
2 small pieces or
½ cup of stewed fruit

- ☐ Does not eat fruit
- ☐ < 1 per day
- ☐ 1 serving
- ☐ 2 servings
- ☐ 3+ servings

2. Does your child eat fruit with the main meals in the day? *(tick at least one)*

Usual refers to most days as opposed to special occasions

- ☐ Does not eat fruit
- ☐ Usually eats fruit as a snack between meals
- ☐ Usually eats fruit with main morning meal
- ☐ Usually eats fruit with main afternoon meal
- ☐ Usually eats fruit with main evening meal
- ☐ Usually has fruit juice with main meals

3. On average how many servings of vegetables does your child eat a day *(tick only one)*

Includes fresh, frozen or canned vegetables (does not include vegetable juices)

One serving = 1 medium piece or
1 cup of salad or
½ cup of cooked veges
i.e. two servings = ½ cup peas + 1 medium potato

- ☐ Does not eat veges
- ☐ < 1 per day
- ☐ 1 serving
- ☐ 2 servings
- ☐ 3 servings
- ☐ 4+ servings

4. On average how many servings of cereal does your child eat a week? *(tick only one)*

Includes: pasta, rice and breakfast cereal (does not include bread)

One serving = 1 cup cooked rice/pasta/porridge or
1/2 cup of muesli or
1 cup of other commercial breakfast cereals or
2 weetbix
i.e. four servings = ¼ cup muesli 2 x per week + 1 weetbix 6 x per week

- ☐ Does not eat cereals
- ☐ < 1 per week
- ☐ 1-2 servings per week
- ☐ 3-4 servings per week
- ☐ 5-6 servings per week
- ☐ 7+ servings per week

5. On average how many servings of bread does your child eat a day? *(tick only one)*

Includes: fresh, toast, rolls, pita

- ☐ Does not eat bread
- ☐ < 1 per day
- ☐ 1-2 servings per day
- ☐ 3-4 servings per day
- ☐ 5-6 servings per day
- ☐ 7+ servings per day

6. What type(s) of bread does your child eat most often?

- ☐ White
- ☐ White high fibre
- ☐ Wholemeal or wholegrain
- ☐ Other *(Specify)* _____

7. Does your child eat bread with the main meals in the day?

Usual refers to most days as opposed to special occasions

- ☐ Does not eat bread
- ☐ Usually eats bread as a snack
- ☐ Usually eats bread with main morning meal
- ☐ Usually eats bread with main afternoon meal
- ☐ Usually eats bread with main evening meal

8. Over the last 4 weeks how many hours per day did your child spend outdoors in the sun?
   - During the week — Average hrs per day_____
   - During the weekend (Sat/Sunday) — Average hrs per day_____

9. Over the last 4 weeks what time of day is your child usually outside?
   - Early morning (7am-11am) — ☐Yes ☐No
   - Middle of the day (11am-3pm) — ☐Yes ☐No
   - Afternoon (3pm-7pm) — ☐Yes ☐No
   - Evening (after 7pm) — ☐Yes ☐No

10. How often does your child eat takeaways (i.e. KFC, Fish & Chips, Chinese Takeaway, Pizza, McDondalds)

Interviewer prompt: "think about breakfast, lunch, dinner and snacks".

☐Never
☐< once per week
☐1-2 times per week
☐3-4 times per week
☐5-6 times per week
☐7+ times per week
☐Don't know
☐Refused

11. How often drink soft drinks or energy drinks?

Includes: coca-cola, pepsi, lemonade, ginger beer, energy drinks, powerade, E2 etc

Excludes: 'diet varieties', fruit juices and drinks, flavoured water and sports water.

☐Never
☐< once per week
☐1-2 times per week
☐3-4 times per week
☐5-6 times per week
☐7+ times per week
☐Don't know
☐Refused

12. How often does your child drink fruit juices and drinks?

Includes: Freshly squeezed juices, just juice, fresh-up, ribena etc

Excludes: diet varieties', soft drinks, energy drinks, flavoured water and sports water

☐Never
☐< once per week
☐1-2 times per week
☐3-4 times per week
☐5-6 times per week
☐7+ times per week
☐Don't know
☐Refused

13. How often does your child eat confectionaries?

Includes: Lollies, sweets, chocolate and potato chips i.e. twisties?

☐Never
☐< once per week
☐1-2 times per week
☐3-4 times per week
☐5-6 times per week
☐7+ times per week
☐Don't know
☐Refused

14. How often to do you offer your child snacks?

☐2-3 x per day
☐A few times a week
☐Rarely offered snacks

15. Does your child eat the following foods?
   - Red meat — ☐Yes ☐No
   - Chicken — ☐Yes ☐No
   - Eggs — ☐Yes ☐No
   - Dairy products — ☐Yes ☐No

16. How often does your child drink cows milk?
- ☐ ≥2 cups daily
- ☐ <2 cups daily or > 3 cups a few days a week
- ☐ <2 cups most days of the week

17. Does your child drink tea? ☐ Yes ☐ No
17.1 **If Yes,** Number of cups per day _____

18. Is your child still being spoon fed? ☐ Yes ☐ No

19. Is your child still drinking from a bottle? ☐ Yes ☐ No

20. How old was your child when s/he stopped having any infant formula or follow-on formula even at bed time? ☐ N/A
Age_____months

21. Does your child have difficulties with;
- Eating ☐ Yes ☐ No
- Gagging ☐ Yes ☐ No
- Chewing ☐ Yes ☐ No
- Swallowing ☐ Yes ☐ No

22. Does your child display the following;
- ☐ Few food restrictions/allergies or sometimes "picky" eater
- ☐ Some food restrictions/ allergies or frequently "picky" eater
- ☐ Extreme food restrictions/allergies or always "picky" eater

23. How often does your child actively play indoors and outdoors
- ☐ Daily
- ☐ <once a day
- ☐ Restricted and minimal daily active play

24. Time spent watching TV, using the computer or playing video games
- ☐ <3hrs daily
- ☐ 3-4hours <u>most</u> days of the week
- ☐ ≥4 hours <u>most</u> days of the Week

<u>Mealtimes:</u>

	Low Risk	**Medium Risk**	**High Risk**
Q25	☐ Occasional mealtime battles and/or parental anxiety/stress	☐ Frequent (daily) mealtime battles and/or parental anxiety/stress	☐ Significant mealtime battles and/or parental anxiety/stress with mealtimes rarely pleasant
Q26	☐ Mealtimes reasonable length (20-30mins)	☐ Usually spends a long time at meals (i.e.1hr) or unable to sit for 15mins at meals	☐ Meal length times always less than 15mins and/or >1 hr
Q27		☐ Food used as reward or punishment frequently	☐ Food used as reward or punishment most of the time
Q28	☐ Meals rarely consumed while watching TV	☐ Meals frequently consumed while watching TV	☐ Meals always/almost always consumed while watching TV
Q29	☐ Adult or parent role model and/or presence at mealtimes	☐ Meals seldom consumed with adult or parent role model and/or presence	☐ Meals rarely or never consumed with adult or parent role model and/or presence

Evaluation:

Q30	☐Good appetite and intake most days of the week	☐Frequent poor appetite with decreased intake	☐Chronic poor appetite with decreased intake
Q31	☐Usually consumes most food groups at or>minimum daily recommended servings and sizes	☐Diet restricted in one food group	☐Diet restricted in more than one food group
Q32		☐minimal use of animal products including milk and eggs	☐Missing one food group entirely
Q33		☐Sometimes given unsafe, inappropriate foods i.e. raw eggs, herbal tea, soft drinks, fruit drinks	☐Frequently given unsafe, inappropriate foods i.e raw eggs, herbal tea, soft drinks, fruit drinks
Q34	☐Adequate food storage and cooking facilities	☐Limited food storage and cooking facilities	☐Inadequate food storage and cooking facilities
Q35	☐Stable family, childcare, social, emotional situation	☐Changes or stresses in family, childcare or social life influencing **some** changes in usual appetite and/or intake and/or growth	☐Changes or stresses in family, childcare or social life influencing **significant or prolonged** changes in usual appetite, intake and/or growth

Summary: Community Health Worker

Overall Evaluation:	***Based on***	**Low Risk**	**Medium Risk**	**High Risk**
Growth, physical and health concerns	*Clinic Summary*			
Food intake, restrictions and supplements	*Q30-33*			
Diet and feeding related factors	*Q10-13,23--29*			
Other risk factor and relevant issues	*Q34, 35*			
Cows milk consumption	*Q16*			
Total				

Clinic Summary:

Low Risk	**Medium Risk**	**High Risk**
☐Weight 2-98th percentile Height 2-98th with < 2 centile difference	☐Weight 2-98th percentile Height 2-98th with >2 centile difference	☐Weight > 98th centile
☐Healthy	☐Recent illness, surgery or hospitalisation	☐Lengthy illness or medical condition
	☐History of iron deficiency, treated with diet	☐History of iron deficiency anemia, treated with diet and medication
☐No dental problems	☐Some problems with teeth or mouth that make it difficult to eat or drink	☐Significant problems with teeth or mouth that make it difficult to eat or drink
☐No GI problems	☐Chronic GI problems which occur a few times a week	☐Chronic GI problems which occur more than twice a week

Summary: Health Professional Opinion

Low Risk Medium Risk High Risk

Healthy Lungs Study

Referral Form for Secondary/Tertiary Respiratory Clinic (Fax: 09 276 0192)

Date of Referral: _____ **Referring Practice:** _____

NHI:_____ **DOB:**_____	**Name:** _____ _____

Respiratory Concerns: ☐ **Yes** ☐ No

If yes, tick at least one;
- ☐ Asthma
- ☐ Cough
- ☐ Crackles
- ☐ CXR findings
- ☐ Clubbing
- ☐ Infection treatment/non responsive to antibiotics
- ☐ Obstructive sleep apnoea
- ☐ Pectus Carinatum / Harrisons Sulci >6 months
- ☐ Suspected aspiration
- ☐ Two subsequent hospital admissions for LRI
- ☐ Other *(Specify)* _____

Nutrition Concerns: ☐ **Yes** ☐ No

If yes, tick at least one;
- ☐ Iron
- ☐ Failure to Thrive > 6 months
- ☐ Obesity (BMI >3SD)
- ☐ Suspected rickets
- ☐ Vitamin D
- ☐ Other *(Specify)* _____

Other Concerns: ☐ **Yes** ☐ No

If yes, tick at least one;
- ☐ Developmental delay
- ☐ Eczema
- ☐ Family concerns:
  - Parental request ☐ Yes ☐ No
  - Child protection ☐ Yes ☐ No
  - Social worker review ☐ Yes ☐ No
- ☐ Heart murmur
- ☐ Recurrent hospitalisation
- ☐ Recurrent infections
- ☐ Second opinion on history/clinical findings
- ☐ Other *(Specify)* _____

Comments:

Contact Lyndsay Le Comte for any queries on 09 2760044 EXT 9153 or 021 803 620

Referral Guidelines 30/12/10 Adrian T

Guidelines for referral to Secondary/Tertiary respiratory clinic.

This clinic will provide consultation/advice in the following areas

1-**Diagnosis**-eg Asthma / bronchiectasis and exclusion of diagnoses eg C.F.
2-**Second opinion** on history/physical findings such as clubbing and non respiratory findings such as heart murmur, developmental delay, growth, failure to thrive, ?ricketts ?osa, UTI, child protection, deep sacral pit, xma etc
3-**Investigation-**HRCT, bronchoscopy, lung function in older children, barium studies, immune function, various blood tests (eg for persistent iron deficiency despite treatment)
4-**Treatment**-intense respiratory treatment using medication and MDT including Physiotherapist, Dietitian and Social Worker.

Specific Respiratory referral criteria:

- CMC unresponsive to 2 courses of 14/7 antibiotic treatment
- Crackles on examination / MCIC persisting after 2 courses of 14/7 antibiotic treatment
- Clubbing on clinical examination at any stage
- Abnormal CXR persisting after 3 months??
- CXR c/w Bronchiectasis at any stage
- CXR showing hilar lymphadenopathy
- Asthma diagnosis? Under 2 years of age-discuss all with secondary/tertiary clinic
- Asthma diagnosed with nurse assessment of response to Ventolin with poor response to steroid prophylaxis after a 3 months trial.
- Clinical suspicion of OSA
- Parental request
- Second opinion on history/clinical findings.
- Further 2 admissions to hospital with LRI
- Clinical suspicion of aspiration
- Harrisons Sulci / pectus carinatum persistent over 6 months

Other specific reasons to refer/discuss

- Poor response to Iron/Vitamin D treatment after 3 months
- Suspicion of Ricketts
- Persisting FTT for greater than 6 months
- Severe obesity (BMI>3 SD)
- Any child protection concerns
- Developmental delay
- Heart murmur
- Xma-poor response to treatment after 3 months
- Second opinion on history/clinical findings

- Need to be seen by a social worker
- Recurrent Infections9multiple sites)eg ENT, cellulitis, xma, insect bites, LRI, tooth abscesses
- Recurrent hospitalisation>4 episodes-any type

Any child can be discussed by telephone if there are any concerns or queries.

Follow up Secondary/Tertiary clinic (circle which)

Patient Label

Date of Clinic _____

1. Current Interventions:

1.1 Respiratory	Yes
1.2 Nutrition	☐No ☐Yes
1.3 Oral Health	☐No ☐Yes
1.4 Hearing	☐No ☐Yes
1.5 Skin	☐No ☐Yes
1.6 Immunisation	☐No ☐Yes
1.7 Smoking Cessation	☐No ☐Yes
1.8 Housing	☐No ☐Yes
1.9 Social	☐No ☐Yes
1.10 Other *(Specify)* _____	☐No ☐Yes

Health Following Enrolment:

2. Did the following symptoms completely disappear following study enrolment?

2.1 Cough ☐**No** ☐Yes ☐Didn't have

2.1.1 **If No,** Nature of cough:
☐Dry
☐Wet
☐Unsure

2.2 Wheeze ☐No ☐Yes ☐Didn't have

3. Has the child had any new illnesses since the last clinic visit?

3.1 Cough ☐No ☐Yes

3.1.1 **If Yes,** Nature of cough:
☐Dry
☐Wet
☐Unsure

3.2 Wheeze ☐No ☐Yes
3.3 Lower respiratory infection ☐No ☐Yes
3.4 Upper respiratory infection ☐No ☐Yes
3.5 Ear infection ☐No ☐Yes
3.6 Skin infection ☐No ☐Yes
3.7 Gastroenteritis ☐No ☐Yes
3.8 Fever unknown cause ☐No ☐Yes
3.9 Other: *(Specify)*_____ _____ _____

4. Has the child received any **new** antibiotics since the last **scheduled** clinic visit? ☐No ☐Yes

5. Other:

Clinical Examination

12. Observations

12.1Temp	12.2 Resp rate per min	12.3 Heart rate per min	12.4 Oxygen sats on air	12.5 Weight	12.6 Length / Height	12.7 Work of breathing
_____	_____	_____	_____% ☐N/A	_____Kg	_____CM	☐Normal ☐Mild ☐Moderate ☐Severe

13. Respiratory Examination *(tick at least one)*

13.1 Normal	☐No	☐Yes	13.6 Chest recession	☐No	☐**Yes**
13.2 Stridor	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
13.3 Wheeze	☐No	☐Yes	13.7 Chest wall deformity	☐No	☐**Yes**
13.4 Crackles	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
13.5 Other*(Specify)*			13.8 Clubbing	☐No	☐Yes
_____	_____		_____		

13.9 Nasal discharge	☐No	☐Yes
13.10 Pharyngitis	☐No	☐Yes
13.11 Enlarged tonsils	☐No	☐Yes

14. Cough during examination ☐No cough ☐Dry ☐Wet

15. Cough during examination (post exercise) ☐No cough ☐Dry ☐Wet

16. Examination of the ears

16.1 **Right Ear** *(tick at least one)*
- 16.1.1 ☐Normal
- 16.1.2 ☐Abnormal
- 16.1.3 ☐Examination not performed

16.2 **Left Ear** *(tick at least one)*
- 16.2.1 ☐Normal
- 16.2.2 ☐Abnormal
- 16.2.3 ☐ Examination not performed

17. Examination of the Heart

17.1 Heart murmur heard	☐No
17.2 Review next clinic	☐No

18. Condition of the Skin *(tick at least one)*

18.1 ☐Normal	18.6 ☐Insect bites
18.2 ☐Impetigo	18.7 ☐Boils
18.3 ☐Tinea	18.8 ☐Cellulitis
18.4 ☐Scabies	18.9 ☐Other, *(Specify)*_____
18.5 ☐Eczema	

Other: _____

_____

_____

_____

_____

_____

19. Assessment:

19.1 ☐ Likely Asthma
19.2 ☐ Likely Bx
19.3 ☐ Likely CSLD
19.4 ☐ No CSLD
19.5 ☐ Tracheomalacia
19.6 ☐ Swallow problems
19.7 ☐ Gastro-oesophagel reflux
19.8 ☐ Other *(specify)* _____

20. Investigations – For follow up

20.1 CXR	☐ No	☐ Yes	☐ Consent not given
20.2 CT Scan	☐ No	☐ Yes	☐ Consent not given
20.3 Nasopharyngeal sample	☐ No	☐ Yes	
20.4 Blood culture	☐ No	☐ Yes	
20.5 Blood tests *(If yes select which)*	☐ No	☐ **Yes**	☐ Consent not given
20.5.1 Iron Studies incl Ferritin and CRP	☐ No	☐ Yes	
20.5.2 Vitamin D	☐ No	☐ Yes	
20.5.3 FBC	☐ No	☐ Yes	
20.5.4 Other *(Specify)*_____			
20.6 Other *(Specify)*_____			

21. Referral; *(tick at least one)*

☐ N/A
☐ Tertiary Care *(Cass)*
☐ EnT
☐ Audiologist
☐ Speech Language Therapist
☐ Social Worker
☐ Primary Care Respiratory Clinic
☐ Other *(Specify)*_____

22. Action:

22.1 Medication prescribed	☐ No	☐ **Yes**
22.1.1 Antibiotics	☐ No	☐ **Yes**
If Yes, *(Specify)* _____		
22.1.2 Bronchodilators	☐ No	☐ **Yes**
If Yes, *(Specify)* _____		
22.1.3 Steroids (oral or IV)	☐ No	☐ Yes
22.1.4 Inhaled Steroids	☐ No	☐ Yes
22.1.5 Other Medication *(Specify)* _____		
22.2 Physiotherapy	☐ No	☐ Yes
22.3 Asthma Review	☐ No	☐ Yes
32.4 Other *(Specify)*_____		

23. Next Appointment: _____

24. Clinical Notes:

Visit 1. Secondary/Tertiary Clinic (circle which)

Patient Label

Date of Clinic _____

1. Current Interventions:

1.1 Respiratory	Yes
1.2 Nutrition	☐No ☐Yes
1.3 Oral Health	☐No ☐Yes
1.4 Hearing	☐No ☐Yes
1.5 Skin	☐No ☐Yes
1.6 Immunisation	☐No ☐Yes
1.7 Smoking Cessation	☐No ☐Yes
1.8 Housing	☐No ☐Yes
1.9 Social	☐No ☐Yes
1.10 Other *(Specify)* _____	☐No ☐Yes

2. Health Following Enrolment:

2.1 Did the following symptoms completely disappear following study enrolment?

2.1.1 Cough	☐**No**	☐Yes	☐Didn't have
2.1.1.1 **If No,** Nature of cough:	☐Dry ☐Wet ☐Unsure		
2.1.2 Wheeze	☐No	☐Yes	☐Didn't have

2.2. Has the child had any new illnesses since the last clinic visit?

2.2.1 Cough	☐No	☐**Yes**
2.2.1.1 **If Yes,** Nature of cough: ☐Dry ☐Wet ☐Unsure		
2.2.2 Wheeze	☐No	☐Yes
2.2.3 Lower respiratory infection	☐No	☐Yes
2.2.4 Upper respiratory infection	☐No	☐Yes
2.2.5 Ear infection	☐No	☐Yes
2.2.6 Skin infection	☐No	☐Yes
2.2.7 Gastroenteritis	☐No	☐Yes
2.2.8 Fever unknown cause	☐No	☐Yes
2.2.9 Other: *(Specify)*_____	_____	_____

3. History of cough:

3.1 Has your child ever had an episode of coughing that lasted more than one month?
☐No ☐**Yes** ☐Unsure

3.1.1 **If yes,** did the episode last more than three months?
☐No ☐Yes ☐Unsure

3.1.2 How bad was your child's cough?
☐Not bad
☐A little
☐Moderate
☐Very bad
☐Extremely bad
☐Unsure

3.2 Does your child cough **every day**?
☐No ☐**Yes** ☐Unsure

3.2.1 **If yes** nature of cough
☐Dry
☐Wet/productive(cough up mucus)
☐Dry and wet
☐Unsure

3.3 Does your child cough **most nights**?
☐No ☐**Yes** ☐Unsure

3.3.1 **If yes** nature of cough
☐Dry
☐Wet/productive(cough up mucus)
☐Dry and wet
☐Unsure

3.4 Does your child cough **with exercise**?
☐No ☐**Yes** ☐Unsure

3.4.1 **If yes** nature of cough
☐Dry
☐Wet/productive(cough up mucus)
☐Dry and wet
☐Unsure

3.5 Has the child ever had a **wet cough**?
☐No ☐Yes ☐Unsure

4. Wheezing:

4.1 Has your child suffered from **wheezing** or **whistling** in the chest or **bronchiolitis** in the last 12 months?
☐No ☐Yes ☐Unsure

4.1.1 How many episodes of wheeze or bronchiolitis: ☐<3 ☐ 3-6 ☐>6
4.1.2 How old was the child when they had their **first episode** _____ months ☐Unsure

4.2 Has your child ever had any of the following medications?

4.2.1 Blue inhalers (Ventolin/Respigen) ☐**Yes** ☐No
If Yes, *Frequency*; ☐Everyday ☐Occasionally

4.2.2 Other inhalers (Flixotide/Pulmicort) ☐**Yes** ☐No
If Yes, *Frequency*; ☐Everyday ☐Occasionally

4.2.3 Oral steroids ie; Redipred/other ☐Yes ☐No
4.2.4 Inhaled steroids ☐Yes ☐No

4.3 How often in the past 12 months have you been **woken up** in the night by the child's whistling/wheezing in the chest?

☐Never
☐Rarely (less than once a month)
☐Sometimes (several weeks over several months)
☐Frequently (2 or more nights a week, almost every month)
☐N/A -does not sleep in the same house as child

4.4. Has your child woken up at night with wheezing prior to this episode?

☐No ☐**Yes** ☐Unsure

4.5 Has a doctor ever told you your child has Asthma?

☐No ☐**Yes**

4.5.1 If Yes, *(whom)* ☐GP ☐Specialist

5. Swallowing dysfunction and reflux:

5.1 When your child feeds do they **vomit**?

☐No ☐**Yes** ☐Unsure

5.1.2 **If Yes**, how often?
☐Most feeds
☐1 or more times per day
☐1 or more times per week
☐Rarely
☐Not sure

5.2 When your child feeds do they **choke,** or **gag**?

☐No ☐**Yes** ☐Unsure

5.2.1 **If Yes**, how often?
☐Most feeds
☐1 or more times per day
☐1 or more times per week
☐Rarely
☐Not sure

Other: _____

_____

_____

_____

_____

_____

Family History:

6. Is there a family history of Bronchiectasis in any of the following:
☐No ☐Mother ☐Father ☐Sibling ☐Unsure ☐Other *(Specify)*_____ _____

7. Is there a family history of Chronic productive cough in any of the following:
☐No ☐Mother ☐Father ☐Sibling ☐Unsure ☐Other *(Specify)*_____ _____

8. Is there a family history of Asthma in any of the following:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

9. Is there a family history of Nasal allergies (allergic rhinitis, hay fever) in any of the following:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

10. Is there a family history of Skin allergies (allergic dermatitis, eczema) in any of the following:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

Other: _____

_____

_____

_____

_____

_____

_____

Clinical Examination

11. Observations

11.1 Temp	11.2 Resp rate per min	11.3 Heart rate per min	11.4 Oxygen sats on air	11.5 Weight	11.6 Length / Height	11.7 Work of breathing
_____	_____	_____	_____% ☐N/A	_____Kg	_____CM	☐Normal ☐Mild ☐Moderate ☐Severe

12. Respiratory Examination *(tick at least one)*

12.1 Normal ☐No ☐Yes
12.2 Stridor ☐No ☐Yes
12.3 Wheeze ☐No ☐Yes
12.4 Crackles ☐No ☐Yes
12.5 Other*(Specify)* _____ _____

12.6 Chest recession ☐No ☐**Yes**
If Yes, ☐Mild ☐Moderate ☐Severe
12.7 Chest wall deformity ☐No ☐**Yes**
If Yes, ☐Mild ☐Moderate ☐Severe
12.8 Clubbing ☐No ☐Yes
_____

12.9 Nasal discharge ☐No ☐Yes
12.10 Pharyngitis ☐No ☐Yes
12.11 Enlarged tonsils ☐No ☐Yes

13. Cough during examination ☐No cough ☐Dry ☐Wet

14. Cough during examination (post exercise) ☐No cough ☐Dry ☐Wet

15. Examination of the ears

15.1 **Right Ear** *(tick at least one)*
15.1.1 ☐Normal
15.1.2 ☐Abnormal
15.1.3 ☐Examination not performed

15.2 **Left Ear** *(tick at least one)*
15.2.1 ☐Normal
15.2.2 ☐Abnormal
15.2.3 ☐ Examination not performed

16. Examination of the Heart

16.1 Heart murmur heard ☐No
16.2 Review next clinic ☐No

17. Condition of the Skin *(tick at least one)*

17.1 ☐Normal
17.2 ☐Impetigo
17.3 ☐Tinea
17.4 ☐Scabies
17.5 ☐Eczema
17.6 ☐Insect bites
17.7 ☐Boils
17.8 ☐Cellulitis
17.9 ☐Other, *(Specify)*_____

Other: _____

_____

_____

_____

_____

_____

18. Assessment:

18.1 ☐ Likely Asthma
18.2 ☐ Likely Bx
18.3 ☐ Likely CSLD
18.4 ☐ No CSLD
18.5 ☐ Tracheomalacia
18.6 ☐ Swallow problems
18.7 ☐ Gastro-oesophagel reflux
18.8 ☐ Other *(specify)* _____

19. Investigations – For follow up

19.1 CXR	☐ No	☐ Yes	☐ Consent not given
19.2 CT Scan	☐ No	☐ Yes	☐ Consent not given
19.3 Nasopharyngeal sample	☐ No	☐ Yes	
19.4 Blood culture	☐ No	☐ Yes	
19.5 Blood tests *(If yes select which)*	☐ No	☐ **Yes**	☐ Consent not given
19.5.1 Iron Studies incl Ferritin and CRP	☐ No	☐ Yes	
19.5.2 Vitamin D	☐ No	☐ Yes	
19.5.3 FBC	☐ No	☐ Yes	
19.5.4 Other *(Specify)*_____			
19.6 Other *(Specify)*_____			

20. Referral; *(tick at least one)*

☐ N/A
☐ Tertiary Care *(Cass)*
☐ EnT
☐ Audiologist
☐ Speech Language Therapist
☐ Social Worker
☐ Primary Care Respiratory Clinic
☐ Other *(Specify)*_____ _____

21. Action:

21.1 Medication prescribed	☐ No	☐ **Yes**
21.1.1 Antibiotics	☐ No	☐ **Yes**
If Yes, *(Specify)* _____		
21.1.2 Bronchodilators	☐ No	☐ **Yes**
If Yes, *(Specify)* _____		
21.1.3 Steroids (oral or IV)	☐ No	☐ Yes
21.1.4 Inhaled Steroids	☐ No	☐ Yes
21.1.5 Other Medication *(Specify)* _____		
21.2 Physiotherapy	☐ No	☐ Yes
21.3 Asthma Review	☐ No	☐ Yes
21.4 Other *(Specify)*_____		

22. Next Appointment: _____

23. Clinical Notes:

Tertiary Clinic - Follow up visit

Patient Label

Date of Clinic _____

1. Is your child still coughing? ☐No ☐**Yes** ☐Unsure
If Yes,1.1 Is it; ☐Better ☐Same ☐Worse
1.2 Is it; ☐Dry ☐Wet ☐Wet and Dry ☐Unsure

2. Other: _____

_____

_____

3. Medications (current): _____

_____

_____

4. Allergies: _____

_____

Clinical Examination

5. Observations

5.1 Temp	5.2 Resp rate / min	5.3 Heart rate / min	5.4 Oxygen sats on air	5.5 Weight	5.6 Length / Height	5.7 Work of breathing
_____	_____	_____	_____% ☐N/A	_____Kg	_____CM	☐Normal ☐Mild ☐Moderate ☐Severe

6. Respiratory Examination *(tick at least one)*

6.1 Normal ☐No ☐Yes
6.2 Stridor ☐No ☐Yes
6.3 Wheeze ☐No ☐Yes
6.4 Crackles ☐No ☐Yes
6.5 Other*(Specify)* _____

6.6 Chest recession ☐No ☐**Yes**
If Yes, ☐Mild ☐Moderate ☐Severe
6.7 Chest wall deformity ☐No ☐**Yes**
If Yes, ☐Mild ☐Moderate ☐Severe
6.8 Clubbing ☐No ☐Yes

6.9 Nasal discharge ☐No ☐Yes
6.10 Pharyngitis ☐No ☐Yes
6.11 Enlarged tonsils ☐No ☐Yes

6.12 Cough during examination ☐No cough ☐Dry ☐Wet
6.13 Cough during examination (post exercise) ☐No cough ☐Dry ☐Wet

7. Examination of the ears

7.1 **Right Ear** *(tick at least one)*
7.1.1 ☐Normal
7.1.2 ☐Otitis media with effusion
7.1.3 ☐Acute otitis media
7.1.4 ☐Acute otitis media with perforation
7.1.5 ☐Chronic suppurative otitis media
7.1.6 ☐Dry perforation
7.1.7 ☐Other *(Specify)*_____

7.2 **Left Ear** *(tick at least one)*
7.2.1 ☐Normal
7.2.2 ☐Otitis media with effusion
7.2.3 ☐Acute otitis media
7.2.4 ☐Acute otitis media with perforation
7.2.5 ☐Chronic suppurative otitis media
7.2.6 ☐Dry perforation
7.2.7 ☐Other *(Specify)*_____

8. Examination of the Heart

8.1 Heart murmur heard ☐No ☐Yes

9. Condition of the Skin *(tick at least one)*

9.1 ☐Normal	9.6 ☐Insect bites
9.2 ☐Impetigo	9.7 ☐Boils
9.3 ☐Tinea	9.8 ☐Cellulitis
9.4 ☐Scabies	9.9 ☐Other,
9.5 ☐Eczema	*(Specify)*_____

10. Teeth examined

☐No Teeth ☐Not examined ☐**Yes**

10.1 **If Yes**, findings	Normal	☐No	☐Yes
	Carries	☐No	☐Yes
	Abscess	☐No	☐Yes
	Gingivitis	☐No	☐Yes
	Extraction	☐No	☐Yes

11. Assessment:

11.1☐Probable CSLD	
11.2☐ Probable Asthma	11.5☐Swallow problems
11.3☐ Probable Bx	11.6☐Gastro-oesophagel reflux
11.4☐ Tracheomalacia	11.7☐Other *(specify)* _____

12. Investigations – (Completed at current visit)

12. Bloods

					Abnormal
12.1 ☐ Respiratory Viral Serology					
	☐IgG	☐Normal	☐Abnormal	☐High	☐Low
	☐IgA	☐Normal	☐Abnormal	☐High	☐Low
	☐IgM	☐Normal	☐Abnormal	☐High	☐Low
	☐IgE	☐Normal	☐Abnormal	☐High	☐Low
12.2 ☐ Blood Tests					
	☐HB	☐Normal	☐Abnormal	☐High	☐Low
	☐WBC	☐Normal	☐Abnormal	☐High	☐Low
	☐ESR	☐Normal	☐Abnormal	☐High	☐Low
	☐CRP	☐Normal	☐Abnormal	☐High	☐Low
12.3 ☐ Vaccination Antibody Protection		☐Normal	☐Abnormal	☐High	☐Low

13. ☐ **Sweat Test**	☐Normal	☐Abnormal
14. ☐ **Video swallow/fluoroscopy**	☐Normal	☐Abnormal

15. ☐ **Bronchoscopy**

15.1 Secretion	☐Normal	☐Excess	☐Purulent
15.2 Appearance	☐Normal	☐Inflamed	
15.3 Structure	☐Normal	☐Abnormal	
15.4 Fat Laden Macrophages	☐Normal	☐Abnormal	
15.5 Bacterial Culture	☐Normal	☐Abnormal *(Specify)* _____	
15.6 Viral Culture	☐Normal	☐Abnormal *(Specify)* _____	
15.7 Fungal	☐Normal	☐Abnormal *(Specify)* _____	

16. ☐ **CT Scan**

16.1 Bronchiectasis	☐Normal	☐Abnormal	☐Severe *(>2 sites i.e. 2 lobes)*
16.2 Air trapping	☐Normal	☐Abnormal	
16.3 Other *(Specify)* _____	_____	_____	

17. ☐ **CXR Date:**____/___/_____*Most recent*

17.1 Bronchiectasis	☐No	☐Yes
17.2 FOC	☐No	☐Yes
17.3 FOA	☐No	☐Yes
17.4 FOI	☐No	☐Yes
17.5 Abnormal	☐No	☐Yes
17.6 Normal	☐No	☐Yes

Management

18. Physiotherapy Recommended

☐No ☐**Yes**

18.1 **If Yes**, ☐ When well
☐ Only when unwell

19. Antibiotics

☐No ☐**Yes**

19.1 **If Yes**, ☐ Short <2 weeks (*Specify)* _____
☐ Long ≥ 2 weeks (*Specify)* _____
☐ Prophylactic (*Specify)* _____

20. Asthma

☐No ☐**Yes**

20.1 **If Yes**, ☐ Beta 2 agonist
☐ Inhaled corticosteroids (IHCS)
☐ Long-acting beta agonists (LABA)
☐ Montelukast
☐ Oral Steroid

21. Other: *(Specify)*_____

22. Referral; *(tick at least one)*

☐N/A
☐Tertiary Care
☐Secondary Care *(Adrian)*
☐ENT
☐Audiologist
☐Speech Language Therapist
☐Social Worker
☐Primary Care Respiratory Clinic
☐Other *(Specify)*_____ _____

23. Next Appointment: _____

24. Clinical Notes:

Tertiary Clinic

Patient Label

Date of Clinic _____

1. History of cough:

1.1 Has your child ever had a cough that lasted more than one month without getting better?

☐No ☐**Yes** ☐Unsure

1.1.1 **If yes,** what type of cough
- ☐Dry
- ☐Wet (mucusy, phlegmy)
- ☐Dry and wet
- ☐Unsure

1.1.2 Did the cough last more than three months? ☐No ☐Yes ☐Unsure

1.2 Does your child cough **every day**? ☐No ☐**Yes** ☐Unsure

1.3 Does your child cough **most nights**? ☐No ☐**Yes** ☐Unsure

1.4 Does your child cough **with exercise**? ☐No ☐**Yes** ☐Unsure

1.5 On a scale of 1 to 10, how troublesome is your child's current cough? *(Tick one)*

1☐ **2**☐ **3**☐ **4**☐ **5**☐ **6**☐ **7**☐ **8**☐ **9**☐ **10**☐

no cough → *most severe cough*

Other: _____

_____

_____

2. History of wheeze:

2.1 Has your child ever had an episode of wheezing that lasted more than one month?

☐No ☐**Yes** ☐Unsure

2.1.1 **If yes,** did the episode last more than three months?

☐No ☐Yes ☐Unsure

2.1.2 How bad was your child's wheeze'
- ☐Not bad
- ☐A little
- ☐Moderate
- ☐Very bad
- ☐Extremely bad
- ☐Unsure

2.1 Does your child wheeze **every day**?

☐No ☐**Yes** ☐Unsure

2.3 Does your child wheeze **most nights**?

☐No ☐**Yes** ☐Unsure

2.4 Does your child wheeze **with exercise**?

☐No ☐**Yes** ☐Unsure

3. Phlegm/Sputum

☐No ☐**Yes**

3.1 **If Yes**, describe
- ☐None
- ☐Clear/White *(non purulent)*
- ☐Yellow/Green *(purulent)*

4. Haemoptysis
☐No ☐**Yes**

5. Shortness of Breath
☐No ☐**Yes**
5.1 **If Yes**, describe
☐None
☐With moderate activity
☐With light activity
☐At rest

6. Has your child ever had an ear infection
☐No ☐**Yes**
6.1 **If Yes**, has your child been reviewed by ENT services ☐No ☐Yes

7. Physiotherapy taught to family
☐No ☐**Yes**
7.1 **If Yes**, Physiotherapy used? ☐No ☐**Yes**
7.1.1 **If Yes, when?** All the time ☐No ☐Yes
When unwell ☐No ☐Yes

8. Child smoke exposed
☐No ☐**Yes**
8.1 **If Yes**, smoke inside ☐No ☐**Yes**

9. Medications (current):

10. Allergies:

11. Family History:
11.1 Is there a family history of Bronchiectasis in any of the following:
☐No ☐Mother ☐Father ☐Sibling ☐Unsure ☐Other *(Specify)*_____ _____
11.2Is there a family history of Chronic productive cough in any of the following:
☐No ☐Mother ☐Father ☐Sibling ☐Unsure ☐Other *(Specify)*_____ _____
11.3Is there a family history of Asthma in any of the following:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure
11.4 Is there a family history of Nasal allergies (allergic rhinitis, hay fever) in any of the following:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure
11.5 Is there a family history of Skin allergies (allergic dermatitis, eczema) in any of the following:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

Other:

Clinical Examination

12. Observations

12.1 Temp	12.2 Resp rate / min	12.3 Heart rate / min	12.4 Oxygen sats on air	12.5 Weight	12.6 Length / Height	12.7 Work of breathing
_____	_____	_____	_____% ☐N/A	_____Kg	_____CM	☐Normal ☐Mild ☐Moderate ☐Severe

13. Respiratory Examination *(tick at least one)*

13.1 Normal	☐No	☐Yes	13.6 Chest recession	☐No	☐**Yes**
13.2 Stridor	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
13.3 Wheeze	☐No	☐Yes	13.7 Chest wall deformity	☐No	☐**Yes**
13.4 Crackles	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
13.5 Other*(Specify)*			13.8 Clubbing	☐No	☐Yes
_____	_____		_____		
13.9 Nasal discharge	☐No	☐Yes			
13.10 Pharyngitis	☐No	☐Yes			
13.11 Enlarged tonsils	☐No	☐Yes			

13.12 Cough during examination ☐No cough ☐Dry ☐Wet
13.13 Cough during examination (post exercise) ☐No cough ☐Dry ☐Wet

14. Examination of the ears

14.1 **Right Ear** *(tick at least one)*	14.2 **Left Ear** *(tick at least one)*
14.1.1 ☐Normal	14.2.1 ☐Normal
14.1.2 ☐Otitis media with effusion	14.2.2 ☐Otitis media with effusion
14.1.3 ☐Acute otitis media	14.2.3 ☐Acute otitis media
14.1.4 ☐Acute otitis media with perforation	14.2.4 ☐Acute otitis media with perforation
14.1.5 ☐Chronic suppurative otitis media	14.2.5 ☐Chronic suppurative otitis media
14.1.6 ☐Dry perforation	14.2.6 ☐Dry perforation
14.1.7 ☐Other *(Specify)*_____	14.2.7 ☐Other *(Specify)*_____

15. Examination of the Heart

15.1 Heart murmur heard ☐No ☐Yes

16. Condition of the Skin *(tick at least one)*

16.1 ☐Normal	16.6 ☐Insect bites
16.2 ☐Impetigo	16.7 ☐Boils
16.3 ☐Tinea	16.8 ☐Cellulitis
16.4 ☐Scabies	16.9 ☐Other,
16.5 ☐Eczema	*(Specify)*_____

17. Teeth examined

☐No Teeth ☐Not examined ☐**Yes**

17.1 **If Yes**, findings	Normal	☐No	☐Yes
	Carries	☐No	☐Yes
	Abscess	☐No	☐Yes
	Gingivitis	☐No	☐Yes
	Extraction	☐No	☐Yes

Other: _____

_____

_____

18. Assessment:

18.1 ☐ Probable CSLD
18.2 ☐ Probable Asthma
18.3 ☐ Probable Bx
18.4 ☐ Tracheomalacia
18.5 ☐ Swallow problems
18.6 ☐ Gastro-oesophagel reflux
18.7 ☐ Other *(specify)* _____

Investigations – (Completed at visit)

19. Bloods

				Abnormal	
19.1 ☐ Respiratory Viral Serology					
	☐ IgG	☐ Normal	☐ Abnormal	☐ High	☐ Low
	☐ IgA	☐ Normal	☐ Abnormal	☐ High	☐ Low
	☐ IgM	☐ Normal	☐ Abnormal	☐ High	☐ Low
	☐ IgE	☐ Normal	☐ Abnormal	☐ High	☐ Low
19.2 ☐ Blood Tests					
	☐ HB	☐ Normal	☐ Abnormal	☐ High	☐ Low
	☐ WBC	☐ Normal	☐ Abnormal	☐ High	☐ Low
	☐ ESR	☐ Normal	☐ Abnormal	☐ High	☐ Low
	☐ CRP	☐ Normal	☐ Abnormal	☐ High	☐ Low
19.3 ☐ Vaccination Antibody Protection		☐ Normal	☐ Abnormal	☐ High	☐ Low

20. ☐ Sweat Test ☐ Normal ☐ Abnormal

21. ☐ Video swallow/fluoroscopy ☐ Normal ☐ Abnormal

22. ☐ Bronchoscopy completed at visit

22.1 Secretion	☐ Normal	☐ Excess	☐ Purulent
22.2 Appearance	☐ Normal	☐ Inflamed	
22.3 Structure	☐ Normal	☐ Abnormal	
22.4 Fat Laden Macrophages	☐ Normal	☐ Abnormal	
22.5 Bacterial Culture	☐ Normal	☐ Abnormal *(Specify)* _____	
22.6 Viral Culture	☐ Normal	☐ Abnormal *(Specify)* _____	
22.7 Fungal	☐ Normal	☐ Abnormal *(Specify)* _____	

23. ☐ CT Scan completed at visit

23.1 Bronchiectasis	☐ Normal	☐ Abnormal	☐ Severe *(>2 sites i.e. 2 lobes)*
23.2 Air trapping	☐ Normal	☐ Abnormal	
23.3 Other *(Specify)* _____	_____	_____	

24. ☐ CXR Date:____/___/_____*Most recent*

24.1 Bronchiectasis	☐ No	☐ Yes
24.2 FOC	☐ No	☐ Yes
24.3 FOA	☐ No	☐ Yes
24.4 FOI	☐ No	☐ Yes
24.5 Abnormal	☐ No	☐ Yes
24.6 Normal	☐ No	☐ Yes

Management

25. Physiotherapy Recommended

☐No ☐**Yes**

25.1 **If Yes**, ☐ When well
☐ Only when unwell

26. Antibiotics

☐No ☐**Yes**

26.1 **If Yes**, ☐ Short <2 weeks (*Specify)* _____
☐ Long ≥ 2 weeks (*Specify)* _____
☐ Prophylactic (*Specify)* _____

27. Asthma

☐No ☐**Yes**

27.1 **If Yes**, ☐ Beta 2 agonist
☐ Inhaled corticosteroids (IHCS)
☐ Long-acting beta agonists (LABA)
☐ Montelukast
☐ Oral Steroid

28. Other: *(Specify)*_____

29. Referral; *(tick at least one)*

☐N/A
☐Tertiary Care
☐Secondary Care *(Adrian)*
☐ENT
☐Audiologist
☐Speech Language Therapist
☐Social Worker
☐Primary Care Respiratory Clinic
☐Other *(Specify)*_____ _____

30. Next Appointment: _____

31. Clinical Notes: _____

Healthy Lungs Study **Follow up Visit 8** Enrolment No:……. NHI:……..……

Date of Clinic _____/_____/_____

Child's Name:…….. **Child's GP:……**

Child's Age:…… **Address: ……...**

Child's DoB:…… **……**

Mother's Name:……... **……...**

Father's Name:…… **Phone:……..**

Other caregiver:……

1. Relation to child: ☐Mother ☐Father ☐Grandparent ☐Aunt/Uncle ☐Other_____

2. What medications is your child taking at the moment?

Name	Dosage	Frequency	Reason

3. Observations

3.1 Temp	3.2 Resp rate per min	3.3 Heart rate per min	3.4 Oxygen sats on air	3.5 Weight	3.6 Length / Height	3.7 Work of breathing
_____	_____	_____	_____% ☐N/A	_____Kg	_____CM	☐Normal ☐Mild ☐Moderate ☐Severe

4. Nurse Observed Cough: ☐None ☐Wet ☐Dry ☐Wet and Dry

Assessment completed by _____ *(Initial)*

Other: _____

_____

_____

_____

_____

4. Respiratory Examination *(tick at least one)*

4.1 Normal	☐No	☐Yes	4.8 Chest recession	☐No	☐**Yes**
4.2 Stridor	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
4.3 Wheeze	☐No	☐Yes	4.9 Chest wall deformity	☐No	☐**Yes**
4.4 Crackles	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
4.5 Clubbing	☐No	☐Yes	4.9.1 Harrisons Sulci	☐No	☐Yes
4.6 Transmitted Sounds	☐No	☐Yes	4.9.2 Pectus Carinatum	☐No	☐Yes
4.7 Other *(Specify)* _____	_____		4.9.3 Pectus Excavatum	☐No	☐Yes

4.10 Nasal discharge	☐No	☐Yes	
4.11 Pharyngitis	☐No	☐Yes	☐Not Examined
4.12 Enlarged tonsils	☐No	☐Yes	☐Not Examined

5. Cough during examination ☐No cough ☐Dry ☐Wet ☐Dry & Wet

6. Cough during examination (post exercise) ☐No cough ☐Dry ☐Wet ☐Dry & Wet ☐N/A

7. Heart murmur heard ☐No ☐Yes
If Yes, ☐Innocent ☐unsure ☐Pathological *(name)* _____

8. **Condition of the skin** *(tick at least one)*

8.1 ☐Normal	8.6 ☐Insect bites
8.2 ☐Impetigo	8.7 ☐Boils
8.3 ☐Tinea	8.8 ☐Cellulitis
8.4 ☐Scabies	8.9 ☐Other, *(Specify)*_____
8.5 ☐Eczema	

9. **Examination of Teeth**
9.1 Examination of teeth completed?
☐No ☐**Yes** *(tick at least one)*

9.1.1 Healthy	☐No	☐Yes
9.1.2 Dental caries present	☐No	☐Yes
9.1.3 Fillings present	☐No	☐Yes
9.1.4 Extractions	☐No	☐Yes
9.1.5 Gingivitis	☐No	☐Yes

10. **Examination of the ears**

10.1 **Right Ear** *(tick at least one)*	10.2 **Left Ear** *(tick at least one)*
10.1.1 ☐Normal	10.2.1 ☐Normal
10.1.2 ☐Wax	10.2.2 ☐Wax
10.1.3 ☐Grommets	10.2.3 ☐Grommets
10.1.4 ☐Otitis media with effusion	10.2.4 ☐Otitis media with effusion
10.1.5 ☐Acute otitis media	10.2.5 ☐Acute otitis media
10.1.6 ☐Acute otitis media with perforation	10.2.6 ☐Acute otitis media with perforation
10.1.7 ☐Chronic suppurative otitis media	10.2.7 ☐Chronic suppurative otitis media
10.1.8 ☐Dry perforation	10.2.8 ☐Dry perforation
10.1.9 ☐Other *(Specify)*_____	10.2.9 ☐Other _____
10.1.10 ☐Not examined	10.2.10 ☐Not examined

11. Assessment: *(CSLD-Chronic Suppurative Lung Disease)*

11.1 Respiratory (Likely Diagnosis)			**11.2 Respiratory (Current)**		
11.1.1 Normal	☐No	☐Yes	11.2.1 Normal	☐No	☐Yes
11.1.2 Two Weeks Antibiotics	☐No	☐Yes	11.2.2 Wheeze	☐No	☐Yes
11.1.3 Likely Asthma	☐No	☐Yes	11.2.3 URTI	☐No	☐Yes
11.1.4 Likely CSLD (incl Bx)	☐No	☐Yes	11.2.4 LRTI	☐No	☐Yes
11.1.5 Viral Wheeze	☐No	☐Yes	11.2.5 Other_____	_____	
11.1.3 Other_____	_____				

11.3 Problem list *(Specify)*

11.3.1 Skin	☐No	☐**Yes**	_____
11.3.2 Ears	☐No	☐**Yes**	_____
11.3.3 Heart	☐No	☐**Yes**	_____
11.3.4 Nutrition	☐No	☐**Yes**	_____
11.3.5 Other	☐No	☐**Yes**	_____

12. Investigations – For follow up

12.1 CXR	☐No	☐Yes	☐Consent not given
12.2 Blood tests *(If yes select which)*	☐No	☐Yes	☐Consent not given
12.2.1 Iron Studies incl Ferritin and CRP	☐No	☐Yes	
12.2.2 FBC	☐No	☐Yes	
12.2.3 Vitamin D	☐No	☐Yes	☐Consent not given
12.2.4 IgE	☐No	☐Yes	☐Consent not given
12.2.5 Other *(Specify)*_____			
12.3 Other *(Specify)*_____	_____		

13. Recommendations/Referral;

13.1 ☐No concerns- Healthy Child

13.2 ☐Review within 1 month _____

13.3 ☐Tertiary Respiratory Clinic _____

13.4 ☐Audiologist _____

13.5 ☐EnT _____

13.6 ☐General Paeds _____

13.7 ☐Paediatric Cardiology

13.8 ☐Own GP _____

13.9 ☐Physiotherapist _____

13.10 ☐Social Worker _____

13.11 ☐Speech Language Therapist _____

13.12 ☐Other *(Specify)*_____ _____

13.13 ☐ Immunisations Required

AGE	(Please tick in box for immunisations recommended)			
	DTaP-IPV Hip-HepB	Hib	MMR	Pneumococcal
5 months	*			*
15 months				*
4 years	(DTap-IPV)*			

Other Immunisations: _____

Other Immunisations: _____

13.14 ☐Medication prescribed ☐No ☐ **Yes**

13.14.1 Antibiotics	☐No	☐ **Yes**
If Yes, (*Specify*) _____		
Indication: Wet cough	☐No	☐ Yes
Ear infection	☐No	☐ Yes
Skin Infection	☐No	☐Yes
Tonsillitis	☐No	☐Yes
Other	☐No	☐Yes
13.15.2 Bronchodilators	☐No	☐ **Yes**
If Yes, (*Specify*) _____		
13.15.3 Steroids	☐No	☐Yes
13.15.4 Inhaled Steroids	☐No	☐Yes
13.15.5 Omeprazole	☐No	☐Yes
13.15.6 Other Medication (*Specify*) _____		

14. Ease of communication: *(Health Literacy/understanding and language barriers)*

☐ No concerns
☐ Some concerns
☐ Significant concerns

Assessment completed by _____ *(Name and designation)*

Referral to tertiary care requires any of:

1. **Wet cough at clinic at a time of stability/wellness (wet cough non responsive to two weeks of antibiotics), AND/OR;**
2. **Crackles or Clubbing on examination AND/OR;**
3. **Abnormal CXR AND/OR;**
4. **Persistent Cough for > 8 weeks in the last 12 months AND/OR;**
5. **Cough > 4 weeks 2 or more times in the last 12 months**

15. Clinical Notes: _____

Year 2 Case Report Form

Two year review

Child's Name:…….. **Child's GP:…….**

Child's Age:…… **Address: ……...**

Child's DoB:…… **……**

Mother's Name:……... **……...**

Father's Name:…… **Phone:……..**

Other caregiver:……

Summary:

Services under: _____

_____

Immunisations up-to-date: ☐**No** ☐Yes ☐Unknown
If No: ☐Overdue for next immunisation
☐No immunisations
Age at 5 month immunisation _____ months

No. Of EC presentations since enrolment: _____
No. of Hospital re-admissions since enrolment: _____
No. of respiratory admissions since enrolment: _____
No. of ICU admissions since enrolment: _____
Total No. of antibiotic prescriptions since enrolment: _____
No. Amoxycillin _____
No. Amoxycillin/Calvulinic acid _____
No. Cefaclor Penicillin _____
No. Cotrimoxasole _____
No. Erythromycin _____
No. Other _____

If patient out of area provide details _____
_____

On Salbutamol ☐No ☐**Yes** ☐Unknown
If Yes, age at 1st Salbutamol prescription: _____ months / years *(circle)*

On IHCS ☐No ☐**Yes** ☐Unknown
If Yes, age at 1st IHCS prescription: _____ months / years *(circle)*

What medications is your child (……..) taking at the moment? (Document any medication)

Name	Dosage	Frequency	Reason

Date of Clinic _____

1. Relation to child: ☐Mother ☐Father ☐Grandparent ☐Aunt/Uncle ☐Other_____

2. *What language(s) are spoken at home?*
☐English ☐Cook Island Maori ☐Mandarin
☐Maori ☐Tongan ☐Hindi
☐Samoan ☐Niuean ☐Other: *(Specify)* _____

3. *Do you think your child* **(……..)** *is healthy?* ☐*All the time* ☐*Most of the time* ☐*Sometimes* ☐*Never*

4. **Household and Housing**

4.1 Do you have other children/ Does **(……..)** have any siblings? ☐No ☐**Yes**
4.1.1 **If Yes**, how many children do you have? ☐2 ☐3 ☐4 ☐5 ☐6 ☐more____

4.2 Does your child **(……..)** go to any of the following:

Te Kohanga Reo	☐No	☐Yes
Pacific language nest	☐No	☐Yes
Kindergarten	☐No	☐Yes
Pre-school	☐No	☐Yes
Day-care	☐No	☐Yes

Other:_____

4.2.1 **If Yes,** How many days a week do they go*?* _____ days
4.2.2 How old were they when they first started going? _____months *(age of first daycare)*

4.3 How many children living in your house at the moment go to a day-care or something similar:
☐0 ☐1 ☐2 ☐3 ☐more _____

4.4 Do you have;

4.4.1 A car for you to use between 9am-5pm	☐No	☐Yes
4.4.2 A mobile phone that you can use?	☐No	☐Yes
4.4.3 A landline phone that you can use?	☐No	☐Yes

4.5 How many people in your child's house **(……..)** including yourself are currently in paid employment? *(How many in the house go to work/have a job that they get paid for)*
☐0 ☐1 ☐2 ☐3 ☐more _____

5. **Smoking**

5.1 Does the *(Do you)* Mother/Main caregiver smoke cigarettes ☐No ☐Yes ☐Unsure
If Yes, how many cigarettes a day_____
have you tried to quit smoking using NRT/patches/tablets ☐No ☐Yes ☐N/A
5.2 Does the Father smoke cigarettes ☐No ☐Yes ☐N/A
5.3 Do other people living in your child's **(……..)** home smoke ☐No ☐Yes
5.4 How many people living in your child's **(……..)** home at the moment smoke cigarettes:_____

6. Does anyone (relative) in your family have or ever had:

6.1 Bronchiectasis:
☐No ☐Mother ☐Father ☐Sibling ☐Unsure ☐Other *(Specify)*_____ _____

6.2 Chronic wet cough (everyday): *(phlegmy / mucousy)*
☐No ☐Mother ☐Father ☐Sibling ☐Unsure ☐Other *(Specify)*_____ _____

6.3 Asthma:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

6.4 Nasal allergies (allergic rhinitis, hay fever):
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

6.5 Skin allergies (allergic dermatitis, eczema):
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

6.6 Tuberculosis:
☐No ☐Sibling ☐Parent ☐Aunt/Uncle ☐Grandparent ☐Unsure

7. Observations

7.1 Temp	7.2 Resp rate per min	7.3 Heart rate per min	7.4 Oxygen sats on air	7.5 Weight	7.6 Length / Height	7.7 Work of breathing
_____	_____	_____	_____% ☐N/A	_____Kg	_____CM	☐Normal ☐Mild ☐Moderate ☐Severe

8. Nurse Observed Cough: ☐None ☐Wet ☐Dry ☐Wet and Dry

Assessment completed by _____ *(Initial)*

Notes: _____

PAEDIATRICIAN Assessment

9. Are you worried about your child's **(……..)** health?

☐No ☐**Yes**

9.1 Respiratory *(breathing problems)*	☐No	☐**Yes**
9.1.1 **If Yes,** Nature:		☐Asthma/Wheeze ☐Cough ☐**Other**_____
9.2 Growth	☐No	☐Yes_____
9.3 Hearing	☐No	☐Yes_____
9.4 Ear infections	☐No	☐Yes_____
9.5 Development*(Are they normal for their age or slow)*	☐No	☐Yes_____
9.6 Behaviour	☐No	☐Yes_____
9.7 Heart	☐No	☐Yes_____
9.8 Skin infections/Eczema	☐No	☐Yes_____
9.9 Allergies	☐No	☐Yes_____
9.10 Other:*(Specify)*_____	☐No	☐Yes

10. Is your child's health; ☐ the same ☐ better ☐ worse than your other children ☐N/A

11. Have any of your other children spent a night or longer in hospital? ☐No ☐**Yes** ☐N/A
11.1 **If Yes**, *was it due to breathing/chest problems/bronchiolitis*? ☐No ☐Yes

12. Do any of your other children have a problem with coughing? ☐No ☐**Yes** ☐N/A
12.1 **If Yes**, What type of cough ☐Dry ☐Wet ☐ Unsure

13. History of cough:

13.1 Has your child **(…..)** ever had a mucusy, phlegmy **wet cough**? ☐No ☐Yes ☐Unsure

13.2 Over the last 12 months has your child **(…..)** coughed **most days**?
☐No ☐**Yes** ☐Unsure

13.2.1 **If yes** what type of cough
☐Dry
☐Wet (mucusy, phlegmy)
☐Dry and wet
☐Unsure

13.3 In the last 12 months has your child ever had a cough that lasted more than 8 weeks without getting better?
☐No ☐**Yes** ☐Unsure

13.3.1 **If yes,** what type of cough
☐Dry
☐Wet (mucusy, phlegmy)
☐Dry and wet
☐Unsure

13.4 In the last 12 months how many times has your child **(…..)** had a cough for longer than **one** month?
0☐ **1**☐ **2**☐ **more**☐

13.5 Does your child **(…..)** cough **most nights**? ☐No ☐Yes ☐Unsure

13.6 Does your child **(…..)** cough **with exercise**? ☐No ☐Yes ☐Unsure

13.7 Does your child **(…..)** currently have a cough?
☐No ☐**Yes** ☐Unsure

13.7.1 **If yes** what type of cough
☐Dry
☐Wet (mucusy, phlegmy)
☐Dry and wet
☐Unsure

13.8 On a scale of 1 to 10, how troublesome is your child's current cough? *(please tick)*

1☐ **2**☐ **3**☐ **4**☐ **5**☐ **6**☐ **7**☐ **8**☐ **9**☐ **10**☐

no cough *most severe cough*

14. Wheezing:

14.1 Has your child suffered from **wheezing** or **whistling** in the chest or **bronchiolitis** in the last 12 months?
☐No ☐**Yes** ☐Unsure

14.1.1 How many times have they had wheeze or bronchiolitis: ☐<3 ☐ 3-6 ☐>6
14.1.2 How old were they when they had their **first** wheezy illness _____ months ☐Unsure

14.2 Has your child ever had any of the following medications?

14.2.1 Blue inhalers (Ventolin/Respigen) ☐ No ☐ **Yes**
If Yes, *how often*; ☐Everyday ☐Occasionally

14.2.2 Inhaled steroids (Flixotide/Pulmicort) ☐ No ☐ **Yes**
If Yes, *how often*; ☐Everyday ☐Occasionally

14.2.3 Oral steroids ie; Redipred/other ☐ No ☐ Yes

14.3 How often in the past 12 months have you been **woken up** in the night by your child's whistling/wheezing in the chest?

☐Never
☐Rarely (less than once a month)
☐Sometimes (several weeks over several months)
☐Frequently (2 or more nights a week, almost every month)
☐N/A -does not sleep in the same house as child

14.4 Has a doctor ever told you your child **(…..)** has Asthma?

☐No ☐**Yes**

14.4.1 **If Yes,** *(whom)* ☐GP ☐Specialist

14.5 Does your child **(…..)** snore when sleeping?

☐No ☐**Yes**

14.5.1 **If Yes**, Do they snore more than half the night? ☐No ☐**Yes** ☐Unsure

If Yes, 14.5.1.1 Do they snore loudly? ☐No ☐Yes

14.5.1.2 Do they have trouble breathing or struggle to breathe ☐No ☐**Yes** ☐Unsure

15. Swallowing dysfunction and reflux:

15.1 Did your child ever have a problem with; *(Describe)*

15.1.1 Vomiting ☐No ☐Yes_____
15.1.2 Choking ☐No ☐Yes_____
15.1.3 Gagging ☐No ☐Yes_____
15.1.4 Other feeding problems _____

15.2 Have you been ever been told by a doctor that your child has Gastro-oesophageal reflux

☐No ☐Yes

Other:

16. Respiratory Examination *(tick at least one)*

16.1 Normal	☐No	☐Yes	16.9 Chest recession	☐No	☐**Yes**
16.2 Stridor	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
16.3 Wheeze	☐No	☐Yes	16.9 Chest wall deformity	☐No	☐**Yes**
16.4 Crackles	☐No	☐Yes	**If Yes,** ☐Mild ☐Moderate ☐Severe		
16.5 Clubbing	☐No	☐Yes	16.9.1 Harrisons Sulci	☐No	☐Yes
16.6 Transmitted Sounds	☐No	☐Yes	16.9.2 Pectus Carinatum	☐No	☐Yes
16.7 Other *(Specify)*			16.9.3 Pectus Excavatum	☐No	☐Yes
_____	_____				

16.10 Nasal discharge	☐No	☐Yes		
16.11 Pharyngitis	☐No	☐Yes	☐	Not Examined
16.12 Enlarged tonsils	☐No	☐Yes	☐	Not Examined

17. Cough during examination ☐No cough ☐Dry ☐Wet ☐Dry & Wet

18. Cough during examination (post exercise) ☐No cough ☐Dry ☐ Wet ☐Dry & Wet ☐N/A

19. Heart murmur heard ☐No ☐Yes
If Yes, ☐Innocent ☐unsure ☐Pathological *(name)* _____

20. **Condition of the skin** *(tick at least one)*

20.1 ☐Normal	20.6 ☐Insect bites
20.2 ☐Impetigo	20.7 ☐Boils
20.3 ☐Tinea	20.8 ☐Cellulitis
20.4 ☐Scabies	20.9 ☐Other, *(Specify)*_____
20.5 ☐Eczema	

21. **Examination of Teeth**
21.1 Examination of teeth completed?
☐No ☐**Yes** *(tick at least one)*

21.1.1 Healthy	☐No	☐Yes
21.1.2 Dental caries present	☐No	☐Yes
21.1.3 Fillings present	☐No	☐Yes
21.1.4 Extractions	☐No	☐Yes
21.1.5 Gingivitis	☐No	☐Yes

22. **Examination of the ears**

22.1 **Right Ear** *(tick at least one)*	20.2 **Left Ear** *(tick at least one)*
22.1.1 ☐Normal	22.2.1 ☐Normal
22.1.2 ☐Wax	22.2.2 ☐Wax
22.1.3 ☐Grommets	22.2.3 ☐Grommets
22.1.4 ☐Otitis media with effusion	22.2.4 ☐Otitis media with effusion
22.1.5 ☐Acute otitis media	22.2.5 ☐Acute otitis media
22.1.6 ☐Acute otitis media with perforation	22.2.6 ☐Acute otitis media with perforation
22.1.7 ☐Chronic suppurative otitis media	22.2.7 ☐Chronic suppurative otitis media
22.1.8 ☐Dry perforation	22.2.8 ☐Dry perforation
22.1.9 ☐Other *(Specify)*_____	22.2.9 ☐Other _____
22.1.10 ☐Not examined	22.2.10 ☐Not examined

23. Assessment:

23.1 Respiratory (Likely Diagnosis)			**23.2 Respiratory (Current)**		
23.1.1 Normal	☐No	☐Yes	23.2.1 Normal	☐No	☐Yes
23.1.2 Two Weeks Antibiotics	☐No	☐Yes	23.2.2 Wheeze	☐No	☐Yes
23.1.3 Likely Asthma	☐No	☐Yes	23.2.3 URTI	☐No	☐Yes
23.1.4 Likely CSLD (incl Bx)	☐No	☐Yes	23.2.4 LRTI	☐No	☐Yes
23.1.5 Viral Wheeze	☐No	☐Yes	23.2.5 Other_____	_____	
23.1.6 Other_____	_____				

(CSLD-Chronic Suppurative Lung Disease)

23.3 Problem list *(Specify)*

23.3.1 Skin	☐No	☐**Yes**	_____
23.3.2 Ears	☐No	☐**Yes**	_____
23.3.3 Heart	☐No	☐**Yes**	_____
23.3.4 Nutrition	☐No	☐**Yes**	_____
23.3.5 Other	☐No	☐**Yes**	_____
			_____

24. Investigations – For follow up

24.1 CXR	☐No	☐Yes	☐Consent not given
24.2 Blood tests *(If yes select which)*	☐No	☐Yes	☐Consent not given
24.2.1 Iron Studies incl Ferritin and CRP	☐No	☐Yes	
24.2.2 FBC	☐No	☐Yes	
24.2.3 Vitamin D	☐No	☐Yes	☐Consent not given
24.2.4 IgE	☐No	☐Yes	☐Consent not given
24.2.5 Other *(Specify)*_____			
24.3 Other *(Specify)*_____			_____

25. Recommendations/Referral;

25.1 ☐No concerns- Healthy Child

25.2 ☐Review within 1 month _____

25.3 ☐Tertiary Respiratory Clinic _____

25.4 ☐Audiologist _____

25.5 ☐EnT _____

25.6 ☐General Paeds _____

25.7 ☐Paediatric Cardiology _____

25.8 ☐Own GP _____

25.9 ☐Physiotherapist _____

25.10 ☐Social Worker _____

25.11 ☐Speech Language Therapist _____

25.12 ☐Other *(Specify)*_____ _____

25.13 ☐ Immunisations Required

AGE	(Please tick in box for immunisations recommended)			
	DTaP-IPV Hip-HepB	Hib	MMR	Pneumococcal
5 months	*			*
15 months				*
4 years	(DTap-IPV)*			

Other Immunisations: _____

Other Immunisations: _____

26. ☐Medication prescribed ☐No ☐ **Yes**

26.1 Antibiotics	☐No	☐ **Yes**
If Yes, (*Specify*) _____		
Indication: Wet cough	☐No	☐ Yes
Ear infection	☐No	☐ Yes
Skin Infection	☐No	☐Yes
Tonsillitis	☐No	☐Yes
Other	☐No	☐Yes_____
26.2 Bronchodilators	☐No	☐ **Yes**
If Yes, (*Specify*) _____		
26.3 Steroids	☐No	☐Yes
26.4 Inhaled Steroids	☐No	☐Yes
26.5 Omeprazole	☐No	☐Yes
26.6 Other Medication (*Specify*) _____		

27. Ease of communication: *(Health Literacy/understanding and language barriers)*

☐ No concerns
☐ Some concerns
☐ Significant concerns

Assessment completed by _____ *(full name and designation)*

Referral to tertiary care requires any of:
1. Wet cough at clinic at a time of stability/wellness (wet cough non responsive to two weeks of antibiotics), AND/OR;
2. Crackles or Clubbing on examination AND/OR;
3. Abnormal CXR AND/OR;
4. Persistent Cough for > 8 weeks in the last 12 months AND/OR;
5. Cough > 4 weeks 2 or more times in the last 12 months

28. Clinical Notes: