

Questionnaire for NZPSU

NATIONAL CLINICAL STUDY TO IDENTIFY PATIENTS WITH FOREGUT AND HINDGUT MALFORMATIONS
Children's Cancer and Developmental Genetic Research Group, CSM, Otago University.

1st 2 initials of last name:	_____	DOB:	_____		
1st 2 initials of first name:	_____	DOA:	_____		
Age (months):	_____	Sex:	_____		
Birth Weight:	_____	Gestation:	_____ (Wks)		
Age of Mother:	_____	Multiple Pregnancy:	_____		
Child's Ethnicity	European/Pakeha <input type="checkbox"/>	Maori <input type="checkbox"/>	Pacific Islander <input type="checkbox"/>	Asian <input type="checkbox"/>	Other <input type="checkbox"/>
Hospital:	_____				
Paediatric Surgeon:	_____		Neonatologist/Paediatrician	_____	
Contact Phone & Fax:	_____		Contact Phone & Fax:	_____	
E-mail:	_____		E-mail:	_____	
Diagnosis:	_____				

Foregut Malformations <input type="checkbox"/>	Hindgut Malformations <input type="checkbox"/>
Oesophageal atresia with distal Tracheo-oesophageal Fistula <input type="checkbox"/>	Imperforate Anus, High Type with fistula <input type="checkbox"/>
Oesophageal atresia (other types) <input type="checkbox"/>	Imperforate Anus, High Type without fistula <input type="checkbox"/>
Laryngo-tracheo-oesophageal Cleft <input type="checkbox"/>	Imperforate Anus, Low Type <input type="checkbox"/>
Foregut Duplication <input type="checkbox"/>	Hindgut Duplication <input type="checkbox"/>
Bronchogenic Cyst <input type="checkbox"/>	Cloacal Malformation <input type="checkbox"/>
Pulmonary Sequestration <input type="checkbox"/>	Currarino Triad <input type="checkbox"/>
Other (foregut), Please specify <input type="checkbox"/>	Other (hindgut), Please specify <input type="checkbox"/>

Associated Anomalies:	✓ Congenital Heart Diseases:	<input type="checkbox"/>	Please Specify: _____
	✓ Urogenital Malformations:	<input type="checkbox"/>	Please Specify: _____
	✓ Gastrointestinal Disorders:	<input type="checkbox"/>	Please Specify: _____
	✓ Skeletal Defects:	<input type="checkbox"/>	Please Specify: _____
	✓ Other (including chromosomal):	<input type="checkbox"/>	Please Specify: _____

Family Details:	1. Number of Siblings:	_____	Don't know <input type="checkbox"/>
	2. Siblings with congenital malformations?:	_____	Don't know <input type="checkbox"/>
	3. Family history including other congenital malformations:	_____	Don't know <input type="checkbox"/>

Any other relevant information (e.g. Karyotype, if known): _____

Thank you for completing this questionnaire. Please return back in 'reply paid' envelope to:

Dr. Parkash Mandhan, PhD Student, Children's Cancer and Developmental Research Group, C/- Department of Paediatric Surgery, Christchurch Hospital, Private Bag 4710, Christchurch or E-mail to: parkash.mandhan@chmeds.ac.nz