NEW ZEALAND PAEDIATRIC SURVEILLANCE UNIT FAS STUDY

Please keep a record of the child's unit number in your NZPSU folder. Please ring Alison Leversha if you have any problems with the form. Thank you for your time.

Reporting Clinician

1. NZPSU Dr. Code ☐☐☐
2. Month/Year of Report ...../.....

Patient

3. First 2 letters of first name ☐☐
4. First 2 letters of surname ☐☐
5. Date of Birth: ☐☐/☐☐/☐☐
6. Sex ☐ M ☐ F

Diagnosis

☐ Definite FAS ☐ Suspected FAS

Age at diagnosis ☐☐ yrs and ☐☐ months

Who first suspected the diagnosis of FAS?

☐ Paediatrician ☐ GP ☐ Parents/caregivers
☐ SES/school ☐ Social Workers ☐ Neonatologists
☐ Geneticist ☐ CYPS ☐ Mental health professionals
☐ Other (specify)_____

Reasons for referral to Paediatrician (tick as many as apply)

☐ Growth disturbance ☐ Behaviour ☐ Learning disorder
☐ Dysmorphic features ☐ School performance ☐ Adoption assessment
☐ Paediatric assessment following diagnosis of FAS by another professional (eg. mental health)
☐ Maternal history of alcohol use/abuse
☐ Other (specify)_____

Demographic data

Mother's current age ☐☐ years ☐ Unknown

Patient's place of birth ☐ NZ
☐ Other (specify)_____

Living circumstances ☐ Lives with biological parent(s)
☐ Lives with other family member(s)
☐ Adopted/foster care

Ethnicity (multiple ethnicities can be given) ☐ European ☐ NZ Maori
☐ Cook Island Maori ☐ Samoan
☐ Tongan ☐ Niuean
☐ Other Pacific Island ☐ Asian
☐ Other_____ (specify)

Diagnostic criteria

Growth (please answer each question)

	☐ ≤ 3rd centile	☐ 3-10th centile	☐ > 10th centile	☐ Not known (NK)
Birth weight	☐	☐	☐	☐
Birth length	☐	☐	☐	☐
Minimum Postnatal weight	☐	☐	☐	☐
Minimum Postnatal height	☐	☐	☐	☐

Gestation at birth_____ weeks Age at minimum postnatal weight_____

Growth parameters corrected for parental centiles ☐ Yes ☐ No ☐

Facial features (please answer each question)

	☐ ≤ -2 SD	☐ -1 to -2 SD	☐ > -1 SD	☐ NK
Palpebral fissures (see fig.)	☐	☐	☐	☐
Smooth philtrum	☐ Yes	☐ No	☐ NK	
Thin upper lip	☐ Yes	☐ No	☐ NK	
Flat midface	☐ Yes	☐ No	☐ NK	

CNS involvement (please answer each question)

	☐ Yes	☐ No	☐ NK		☐ Yes	☐ No	☐ NK
OFC ≤ -2 SD	☐	☐	☐	Abnormalities on CNS imaging	☐	☐	☐
IQ ≤ 60	☐	☐	☐	Hypertonia/hypotonia	☐	☐	☐
Seizure disorder	☐	☐	☐	Tremors/marked incoordination	☐	☐	☐
Developmental delay	☐	☐	☐	Behavioural dysfunction/deficit	☐	☐	☐
Language disorder	☐	☐	☐	Mild intellectual impairment	☐	☐	☐
ADHD	☐	☐	☐	Sensorineural hearing loss	☐	☐	☐
Myopia/hyperopia	☐	☐	☐				

Gestational alcohol exposure (please give one response to section a and one to section b)

a) Reported by
- ☐ mother
- ☐ someone who saw mother drink during pregnancy
- ☐ from other reliable source
- ☐ no reliable report of alcohol

b) Amount/frequency
- ☐ ≥4 standard drinks at one sitting ≥ weekly in the 1st trimester
- ☐ ≥4 standard drinks at one sitting < weekly in the 1st trimester
- ☐ <4 standard drinks at one sitting ≥ weekly in the 1st trimester
- ☐ <4 standard drinks at one sitting < weekly in the 1st trimester
- ☐ reliable report of alcohol in 1st trimester: quantity/frequency unknown

History of other drug/substance use during pregnancy (please answer each question)

	☐ Yes	☐ No	☐ NK	If yes, which and how frequently
Drugs	☐	☐	☐	_____
Solvents	☐	☐	☐	If yes, how frequently_____
Cigarettes	☐	☐	☐	If yes, number/day in first trimester_____

Agencies involved (please answer each question)

	☐ Yes	☐ No	☐ NK		☐ Yes	☐ No	☐ NK
SES	☐	☐	☐	Mental Health	☐	☐	☐
Justice dept	☐	☐	☐	Child Development	☐	☐	☐
Respite services	☐	☐	☐	Other(specify)_____			

Thank you for your help. Please return in the addressed reply-paid envelope. Please keep the patient's name and other details in your NZPSU folder.