

COLLABORATIVE HIV PAEDIATRIC STUDY (CHIPS) FOLLOW-UP FORM

SHADED BOX FOR OFFICE USE <small>(Form date: 07/08/09)</small>	CHIPS no:	Date of last report _ / _ / _	
PENTA trial no(s):	CSTU no:		
Date of birth:	Hospital no:	Initials:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Paediatrician:	Main hospital:		

1. Has the child been in shared care since last report (*date above*)? Yes No
If Yes, where? _____

2 a. Has the child had any new category B or C (AIDS) events since last report (*date above*)? Yes No

b. If Yes, please specify and circle for each disease the method of diagnosis (Definitive or Presumptive)
For definitions of category B, please see appendix 1 and for category C, please see appendix 2.

Category B and C (AIDS) conditions Please specify below	Date of onset	Category B or C	Method of diagnosis	Drugs/Treatment administered (not ART)
		B C	D P	
		B C	D P	

3 a. Has the child had any hospital inpatient stays since the last report (*date above*)? Yes No

b. If Yes, please give details below.

Name of hospital	Ward (paediatric, HDU or ICU)	Date of admission	Date of discharge	Diagnosis and drugs/treatment administered (not ART)	For office use only (coding)

4 a. Is the child co-infected with hepatitis B or C?

Hepatitis B (HBV): Yes No Never tested

Hepatitis C (HCV): Yes No Never tested

b. If Yes or No for either HBV or HCV, please give **most recent** test results (including negative results) & treatment.

HBV marker	Pos	Neg	Date	Not tested	HCV marker	Pos	Neg	Date	Not tested
HBsAg	<input type="checkbox"/>	<input type="checkbox"/>			Anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>		
HBeAg	<input type="checkbox"/>	<input type="checkbox"/>			HCV PCR	<input type="checkbox"/>	<input type="checkbox"/>		
HBV viral load	c/ml				HCV viral load	c/ml			
Other HBV (specify).....	<input type="checkbox"/>	<input type="checkbox"/>			Treated for HBV/HCV?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, specify:.....	

5. Please give all results since the last report (*date above*).

Date	Weight (kg)	Height (cm)	Date	CD4	CD4%	CD8	CD8%	Total lymphocytes	Date	HIV-1 RNA viral load	
										Copies/ml	Kit/cut off

6 a. Has the child had any adverse events possibly related to ART? (Grade 2 or above) Yes No

b. If Yes, please list details below (for definitions please see Appendix 4).

Event: specify	Date of onset <i>ddmmyy</i>	Date resolved (or tick box if ongoing) <i>ddmmyy</i>	Worst grade	Related drug (if known)	Reported to Yellow Card		ART stopped/modified (see 10b)		Comments
					Yes	No	Yes	No	
		<input type="checkbox"/>							
		<input type="checkbox"/>							

7 a. Does the child have lipodystrophy? Yes Probable No NK

b. If Yes or Probable, onset date: ___/___/___ and please tick appropriate boxes below (for definition please see appendix 6)

		Mo / Yr						
b1) Body fat changes		None	Mild	Moderate	Severe	b2) Investigations undertaken		
		Yes	No			Yes	No	
i) Fat accumulation	Neck					Limb/waist etc. measurement		
	Breast					Skinfold thickness		
	Abdomen					DEXA scan (measure body fat)		
ii) Lipoatrophy	Face					DEXA scan (measure bone density)		
	Arms					MRI scan		
	Legs					CT scan		
	Prominent veins					Body Impedance Analysis		

b3) Action taken: observation change of ART anti lipid therapy surgery
 other _____

8. Blood lipids: Not Done Triglycerides ___ mmol/l, Cholesterol ___ mmol/l Date ___/___/___ Fasting: Yes No

9 a. Tanner stage: Date examined: ___/___/___ Female Breast ___ Male Genitalia ___ Pubic Hair ___ Not done

b. Onset of menarche since last assessment? Yes No If Yes, give month of onset: ___/___

10a. Has there been any change in antiretroviral therapy and/or doses since last report? Yes No

b. If Yes, list all antiretroviral drugs taken. See appendix 3 for coding of reasons.

Drug	Individual dose (mg) & frequency	Formulation	Date started	Date stopped	Reason(s) for start	Reason(s) for stop/change

11. Was a resistance test requested since last report? Yes No If Yes, date ___/___/___

12 a. Is the child currently receiving any PCP prophylaxis? Yes No Never started

b. If Yes, Drug: _____ Date started: ___/___/___ If No, Drug: _____ Date stopped: ___/___/___

13. Date of most recent examination: ___/___/___

14. Postcode of child's residence at most recent examination (without last letter): _____

15. Death Please complete this section if the child has died since the last report (date overleaf).

a. Date of death: ___/___/___ b. Cause of death and details: _____

c. Was the death: (tick one or more): HIV-related Not HIV-related Possibly drug-related Of unknown cause

16. If you have not seen this child since the last report (date overleaf), is s/he Due for an appointment ___/___/___

Transferred to another paediatric centre ; If so, which centre? _____

Transferred to adult care ; If so, which centre? _____

Known to have left the country Lost to follow-up Other _____

17. Comments:

Completed by: _____ Email: _____ DATE: ___/___/___

Thank you for completing this form. Call us with any queries on 020 7670 4784 or e-mail: chips@ctu.mrc.ac.uk

Please keep the bottom copy for your clinic records and return the top copy to:

CHIPS Data Manager, MRC Clinical Trials Unit, 222 Euston Road, London, NW1 2DA, UK.

These data are being collected in collaboration with the National Study of HIV in Pregnancy and Childhood – call with queries on:

020 7829 8686 or e-mail: nshpc@ich.ucl.ac.uk