DUTY: Diagnosis of Urinary Tract Infections in Young Children Study

DATE ☐☐ / ☐☐ / ☐☐☐☐ **Site ID** ☐☐ **Patient ID** ☐ – ☐☐☐☐

☐

3 MONTHS PRIMARY CARE NOTES REVIEW

DUMMY FORM – NOT FOR PRINTING

(DUTY Research Nurse/Clinical Studies Officer (RN/CSO) to complete)

Practice Details

Practice Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Practice Site ID:** ☐☐

Reviewers Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Child's Details

Patient ID: ☐ – ☐☐☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y)

Gender :
Female ☐ Male ☐

NHS Number: ☐☐☐☐☐☐☐☐☐☐

Study entry date: *(i.e. date of consultation)*: ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y)

Note review end date: *(i.e. 3 month from recruitment)*: ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y)

Patient has left this surgery (*tick if yes*): ☐ **Date** *(if known)*: ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y)

Patient has died (*tick if yes*): ☐ **Date** *(if known)*: ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y)

Please Note:

Data collected here refers to primary care contacts in the **3 MONTHS *AFTER*** the initial recruitment visit (for example, if recruited on 10/Sept/2010, 3month review end date is 10/Dec/2010).

Please do not include data recorded at the initial recruitment visit; any subsequent contacts on the day of recruitment can be included.

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Primary Care Visits

Please record **how many** consultations (not including routine immunisations and screening checks) have taken place.

1. PRACTICE- BASED CONTACTS IN- HOURS	**Number of contacts**
General Practitioner at the surgery	☐☐
Practice Nurse/Nurse Practitioner at the surgery	☐☐
Telephone consultation with doctor at the surgery	☐☐
Telephone consultation with nurse at the surgery	☐☐
Home visit by the doctor	☐☐

2. OUT- OF- HOURS CONTACTS FROM OOH CENTRE	
Out-of Hours telephone contact - nurse	☐☐
Out-of Hours telephone contact - doctor	☐☐
Out-of Hours face-to-face contact - nurse	☐☐
Out-of Hours face-to-face contact - doctor	☐☐
Out-of-Hours home visit by doctor from OOH centre	☐☐

Please record the number of urine samples sent to the laboratory: ☐☐

Please provide full results below, and attach a copy)

	Date of test	Laboratory Result *(provide microscopy and culture information)* *(please tick if copy of results attached)*
Urine test 1		☐
Urine test 2		☐
Urine test 3		☐
Urine test 4		☐

Hospital Visits

☐ ☐

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3. Has the child attended **any hospital** during the last 3 months? No Yes

If 'Yes' please record information relating to any contacts the child has had below:

Please note: Do not include data from the initial recruitment visit if the child was recruited at an A&E Dept.

4. Accident and Emergency department visits during the last **3 months**?

No ☐
Yes ☐ → Total number of visits: ☐☐

Please record the following for each visit:

	Date of visit	Reason for visit: *please state*
VISIT 1		
VISIT 2		
VISIT 3		

5. Hospital clinic visits during the last **3 months**?

No ☐
Yes ☐ → Total number of visits: ☐☐

Please record the following for each visit:

	Date of visit	Type of Clinic *(e.g. Paediatrics)*	Reason for visit: *please state*
VISIT 1			
VISIT 2			
VISIT 3			

6. Overnight stays in hospital during the last **3 months**?

No ☐
Yes ☐ → Total number of visits: ☐☐

Please record the following for each visit:

	Admission Date	Length of stay *(# of nights)*	Reason for stay: *please state*
VISIT 1			
VISIT 2			
VISIT 3			

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Hospital Tests

7. Has the child had any hospital tests during the last **3 months**?

No ☐
Yes ☐ ⟶ Total number of tests: ☐☐

Please record the following for each test:

	Date of test	Type of test*	Results: *please state*
TEST 1			
TEST 2			
TEST 3			

** e.g. Ultrasound scan (USS), DMSA scan, Micturating Cysto-urethrogram (MCUG), Indirect MAG3 Cystogram, or any other test*

Prescribed Medication

8. Please record details of any **prescribed medication** the child received at the index visit and any subsequent visits in the last 3 months
Please also record any repeat prescriptions.

	Name	Date prescribed	Strength / Dose	Formulation e.g. suspension/ suppository	Quantity and frequency of dose	Length of Dose	Tick if prescribed at recruitment visit
Example	*Trimethoprim*	*01/01/10*	*50mg/5ml*	*Oral suspension*	*5ml twice daily*	*5 days*	
Medicine 1							
Medicine 2							
Medicine 3							
Medicine 4							