DUTY: Diagnosis of Urinary Tract Infections in Young Children Study

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


# SECTION 3: CASE REPORT FORM

(Research Nurse/CSO to ask parent/carer)

## Current Symptoms

How many days (including today) has your child been unwell? Enter number (1- 28) ☐☐

Compared to yesterday is your child same, better or worse? ☐ Same ☐ Better ☐ Worse

Please rate your overall impression of your child's current illness when at its worst from 0-10

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Completely Well | | | | | | | | | | Extremely Unwell |

For each symptom, score symptom when it was at its **worst during this illness**.

| Symptom | Severity | | | | |
|---|---|---|---|---|---|
| | *No Problem* | *Slight Problem* | *Moderate problem* | *Severe problem* | *Don't Know/ NA* |
| Child 'not themselves' (e.g.: clingy; not interested in what's going on; not playing well; low energy/tired; irritable or not settling; crying more than usual). | ☐ | ☐ | ☐ | ☐ | |
| Confused or Disorientated | ☐ | ☐ | ☐ | ☐ | |
| Disturbed sleep | ☐ | ☐ | ☐ | ☐ | |
| Fever at any time during this illness (fever is feeling hot or cold ) | ☐ | ☐ | ☐ | ☐ | |
| Fever now or in the past 24 hours | ☐ | ☐ | ☐ | ☐ | |
| Chills or Shivering | ☐ | ☐ | ☐ | ☐ | |
| New generalised rash with this illness (not worsening of existing skin conditions) | ☐ | ☐ | ☐ | ☐ | |
| Nappy rash or similar | ☐ | ☐ | ☐ | ☐ | |
| Muscle aches or pains all over | ☐ | ☐ | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ | ☐ | ☐ |
| Refused feeds/eating less than normal | ☐ | ☐ | ☐ | ☐ | |
| Poor weight gain or weight loss (in the last month) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vomiting | ☐ | ☐ | ☐ | ☐ | |
| Diarrhoea (at any time) | ☐ | ☐ | ☐ | ☐ | |
| Diarrhoea (in the past 24hrs) | ☐ | ☐ | ☐ | ☐ | |
| Constipation in the last week | ☐ | ☐ | ☐ | ☐ | |
| Abdominal pain/tummy ache/pulling up legs | ☐ | ☐ | ☐ | ☐ | |

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| **Symptom** | **Severity** | | | | |
|---|---|---|---|---|---|
| | *No Problem* | *Slight Problem* | *Moderate problem* | *Severe problem* | *Don't Know/ NA* |
| Passing urine more often | ☐ | ☐ | ☐ | ☐ | ☐ |
| Any changes in urine appearance (darker, cloudy, smelly or blood) | ☐ | ☐ | ☐ | ☐ | ☐ |
| If **YES,** *please state*: | ☐ Darker | ☐ Cloudy | ☐ Smelly | ☐ Bloody | ☐ Other |
| If **Other,** *please describe:* | | | | | |
| Pain/crying when passing urine | ☐ | ☐ | ☐ | ☐ | ☐ |
| Day or bed wetting when previously dry * | ☐ | ☐ | ☐ | ☐ | ☐ |
| Blocked or runny nose | ☐ | ☐ | ☐ | ☐ | |
| Cough | ☐ | ☐ | ☐ | ☐ | |
| Wheeze | ☐ | ☐ | ☐ | ☐ | |
| Short of breath, difficulty breathing or grunting | ☐ | ☐ | ☐ | ☐ | |
| Chest pains | ☐ | ☐ | ☐ | ☐ | ☐ |
| Earache or holding ear/s | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sore throat | ☐ | ☐ | ☐ | ☐ | ☐ |
| More unwell compared to similar previous illnesses | ☐ | ☐ | ☐ | ☐ | |
| Any other symptoms | ☐ | Yes | ☐ | No | |
| If **YES,** *please state:* | | | | | |

** Not applicable for children wearing nappies day & night*

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## Past Medical & Family History

**These questions relate to other medical problems your child has or has had in the past. There are also some questions concerning the pregnancy, birth and early life of the child.**

Not counting today, approximately how many times has your child previously consulted a doctor or nurse for this episode of illness?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐10+

Does your child have any on-going health problems? ☐ Yes ☐ No

If **YES**, *please indicate*:

☐ asthma ☐ diabetes ☐ heart disease ☐ high blood pressure ☐ learning disabilities

☐ other *please specify*:

Was the pregnancy full term for your child? ☐ Yes ☐ No

If **NO**, *please indicate*: ☐ Born Late ☐ Born Early If Early, estimate weeks: ☐☐

Was your child breastfed? ☐ Yes ☐ No

If **YES**, for how long exclusively? ☐ < 3months ☐ ≥ 3months

Were you ever told that your child's kidney, bladder or urinary system was abnormal in any way after a pregnancy ultrasound scan? ☐ Yes ☐ No

If **YES**, *please give details*:

**In boys ONLY** – has your child been circumcised? ☐ Yes ☐ No

**The next set of questions relate to your child and to close family members of your child (this includes mother, father and any brothers or sisters who are blood relatives of the child).**
**We are asking these questions to see whether urine infections run in families.**

Has your child or member of your family ever been diagnosed with vesico-ureteric or 'kidney' reflux? ☐ Yes ☐ No ☐ Don't Know

If **YES**, *please indicate*: ☐ Child ☐ Mother ☐ Father ☐ Sibling

Has your child or any member of your family ever been diagnosed or treated for urine infections? ☐ Yes ☐ No ☐ Don't Know

If **YES**, *please indicate*: ☐ Child ☐ Mother ☐ Father ☐ Sibling

Does your child or any member of your family have any other renal/urinary problem? ☐ Yes ☐ No ☐ Don't Know

If **YES**, *please indicate*: ☐ Child ☐ Mother ☐ Father ☐ Sibling

If **YES**, *please give details*:

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## Medications

Is your child currently taking any medication? ☐ Yes ☐ No

If **YES**, *please indicate:*

☐ laxatives (e.g. lactulose, senna, modecol)
☐ steroid inhaler (e.g. clenil)
☐ beta$_2$ agonist inhaler (e.g. salbutamol)
☐ antihistamine (e.g. piriton)
☐ paracetamol
☐ ibuprofen
☐ other medication (please provide details):

## Toileting behaviour

Does your child use nappies/pull-ups? ☐ Yes ☐ No

If **YES**, *please indicate*: ☐ Day ☐ Night ☐ Both

Approximately how many nappies/pull-ups has your child used in the last 24 hours? *Estimate number* ☐☐

How many times do you usually bath or shower your child in a normal week? *Estimate number* ☐☐

## Examination

To be completed by Research Nurse/CSO or responsible clinician

| | | | | *Please tick here if child refuses to be examined* |
|---|---|---|---|---|
| Temperature | ☐☐•☐ °C | (range 35.0 – 42.0) | | ☐ |
| DUTY standard 'Thermoscan' thermometer used to check temp? | ☐ Yes ☐ No | | | |
| If **NO,** *please indicate*: | ☐ infrared ear | ☐ digital auxiliary | ☐ other: | |
| $O_2$ saturation | ☐☐☐ % | (range 80 – 100%) | | ☐ |
| Pulse rate | ☐☐☐ | (range 80 – 250 bpm) | | ☐ |
| Respiratory rate | ☐☐ | (range 20 – 80 rpm) | | ☐ |
| Capillary refill time* | ☐ < 2 sec | ☐ 2-5 sec | ☐ > 5 sec | ☐ |

** The Advanced Paediatric Life Support manual[1] recommends that this should be done by pressing on the sternum for 5 seconds and then recording the time it takes for the skin colour to change from white back to pink.*

Has the child's responsible clinician been informed of these results? ☐ Yes *NB: this must be done for all children*