Early-onset major depressive disorder (EOMD)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM
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REPORTING INFORMATION
(To be completed by the CPSP Senior Coordinator)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Strict confidentiality of information will be assured.

CASE DEFINITION FOR EARLY-ONSET MAJOR DEPRESSIVE DISORDER

Report any child aged 5 to 12 years of age inclusively, seen in the previous month, with newly diagnosed early-onset major depressive episode, including children with unipolar mood disturbances sufficient to cause a disruption to social, family and/or academic functioning.

"Major depressive episode" is defined in the DSM-IV-TR as:

1) Depressed or irritable mood, most of the day, nearly every day,

OR

2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day,

which is either newly present or has clearly worsened compared with the child's pre-episode status.

AND

At least **four** of the following seven symptoms that are present during the same two-week period as either (1) **or** (2) above. These symptoms occur daily or near daily and represent a distinct change from previous functioning.

1) Significant weight change, failure to make expected weight gains, **or** significant appetite change.
2) Insomnia (difficulty falling asleep, night-waking or waking too early) **or** hypersomnia.
3) Psychomotor agitation **or** retardation: observable by others and does not represent subjective feelings.
4) Fatigue **or** loss of energy.
5) Feelings of worthlessness **or** excessive or inappropriate guilt (not merely guilt about being sick).
6) Diminished ability to think or concentrate, **or** indecisiveness.
7) Recurrent thoughts of death, recurrent suicidal ideation, **or** a suicide attempt.

AND

Impairment in social functioning (social withdrawal, family or peer conflicts) or academic functioning (school refusal, decreased school performance), which is either *newly present or worsened* compared with pre-episode status.

Exclusion criteria

1) Symptoms due to the direct physiological effects of a substance or a general medical condition.
2) Symptoms occurring exclusively during acute bereavement period (within two months after the loss of a loved one). Note: this exclusion does not apply to palliative care patients.
3) A previous diagnosis of a manic episode or bipolar disorder.

Month first seen _____

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: _____ /_____ /_____ (DD / MM / YYYY) 1.2 Sex: Male ___ Female ___

1.3 Ethnicity (check all that apply):

First Nations ___ Innu ___ Inuit ___ Métis ___ Asian ___ Black ___ Caucasian ___

Latin American ___ Middle Eastern ___ Other (specify) _____

Unknown ___

1.4 Was the child born in Canada? Yes ___ No ___ Unknown ___

SECTION 1 – DEMOGRAPHIC INFORMATION (cont'd)

1.5 Whom does the child live with?

___ Both biological parents

___ Biological mother: Is there a step-parent? Yes ___ No ___

___ Biological father: Is there a step-parent? Yes ___ No ___

___ Related non-parental guardian (describe) _____

___ Non-related caregiver (describe) _____

1.6 What is the highest level of education completed by:

the child's mother? Public school ___ High school ___ University/College ___ Unknown ___

the child's father? Public school ___ High school ___ University/College ___ Unknown ___

1.7 Has Child Protection / Welfare ever been involved with this family? Yes ___ No ___ Unknown ___

1.8 Has this child been a victim of violence (physical or sexual), or other maltreatment (e.g., verbal abuse)?

___ no evidence of this

___ confirmed yes (abuse history disclosed to responding clinician)

___ suspected yes (abuse history suspected by responding clinician, but no evidence)

___ don't know (responding clinician cannot confirm or rule out)

SECTION 2 – CLINICAL FEATURES

2.1 Indicate symptoms/signs present and meeting duration and severity criteria outlined in the case defnition (check all that apply).

___ Depressed mood
___ Diminished interest or pleasure
___ Irritability
___ Weight gain
___ Weight loss
___ Failure to make expected weight gain
___ Insomnia
___ Hypersomnia
___ Psychomotor agitation
___ Psychomotor retardation
___ Fatigue or loss of energy
___ Worthlessness or excessive or inappropriate guilt
___ Decreased concentration or indecisiveness
___ Suicidal ideation
___ Suicide attempt
___ Anxiety
___ Non-specific somatic complaints for which no cause is found (e.g., stomachache)

2.2 Indicate the realm in which the child's functioning has been impaired (check all that apply).

Social activities ___ Extracurricular activities ___ Family ___ School ___

2.3 Indicate, to the best of your ability, the timeline and the path that this patient followed in the receipt of diagnosis and treatment.

2.3.1 Duration of symptoms prior to presentation: _____ months OR _____ years

2.3.2 Duration of symptoms prior to receiving diagnosis of depression:

< 2 months ___ 2-6 months ___ 6-12 months ___ 1-2 years ___ > 2 years ___

2.3.3 Date of diagnosis: _____ /_____
MM YYYY

2.3.4 To whom was the child and/or parents' initial presentation for help?

Family physician ___ Paediatrician ___ School teacher or other school employee ___

Community health centre ___ Previously known case worker ___

Hospital emergency room / urgent care walk-in ___ Other, specify _____

SECTION 2 – CLINICAL FEATURES (cont'd)

2.3.5 Indicate professionals that the child/parent has consulted in the assessment of these symptoms:
Family physician ___ Paediatrician ___ Child psychiatrist ___
School staff (teacher, counselor, etc.) ___ Other health professional, specify (e.g., naturopath)
_____

2.3.6 Who first made the diagnosis of depression?
Family Physician ___ Paediatrician ___ Psychiatrist ___
Other (e.g., emergency physician) _____

SECTION 3 – MEDICAL HISTORY

3.1 Does the child have a pre-existing medical illness? Yes ___ No ___ Unknown ___
If yes, specify: the diagnosis _____
current medications required _____

SECTION 4 – PSYCHIATRIC ILLNESS

		Yes	No	Unknown
4.1	Does the child have a comorbid psychiatric condition			
4.1.1	Attention deficit hyperactivity disorder?	___	___	___
4.1.2	Anxiety disorder?	___	___	___
4.1.3	Oppositional defiant disorder?	___	___	___
4.2	Does the child have a diagnosed learning disability?	___	___	___
	Any other psychiatric illness, specify: _____			
4.3	Is there a history of self-harm behaviour (e.g., cutting)?	___	___	___
4.4	Does the child use any of the following substances?			
4.4.1	Cigarettes	___	___	___
	If yes, how many per day? < 5 ___ 5-10 ___ > 10 ___			
4.4.2	Alcohol	___	___	___
	If yes, how many drinks/week? ≤ 2 ___ 3-5 ___ > 5 ___			
4.4.3	Other substances of abuse?	___	___	___
	If yes, specify which substances have been used: _____			
4.5	Is there a known history of psychiatric illness (including substance disorder) in either biological parent or sibling?	___	___	___
	If yes, specify: diagnosis _____			
	relationship to child _____			
4.6	Does the child participate in any internet-related social networking groups, such as Facebook, Formspring?	___	___	___
	If yes, list names, if known: _____			

SECTION 5 – EXAMINATION FINDINGS

5.1 Current weight: _____ kg
5.2 Current height: _____ cm
5.3 Pubertal status: Pre-pubertal ___ Underway ___ Complete ___
5.4 Has the child reached menarche? Yes ___ No ___ N/A ___

SECTION 5 – EXAMINATION FINDINGS (cont'd)

5.5 Describe the child's physical examination: Normal ___ Abnormal ___

If abnormal, describe:

_____

SECTION 6 – MANAGEMENT

6.1 Has the child been offered treatment? Yes ___ No ___ Refused treatment ___

If yes, specify date: _____ /_____
MM YYYY

If no, would you have offered treatment if services were available? Yes ___ No ___

6.2 Indicate the treatment(s) for which the child was referred, and if received, **date of treatment initiation.**

MM / YYYY

6.2.1 Referred child _____ /_____

6.2.2 Treatment initiated

- Psychotropic medication: specify_____ _____ /_____
  specify_____ _____ /_____
  specify_____ _____ /_____
- Psychotherapy
  Cognitive-behavioural therapy _____ /_____
  Family therapy _____ /_____
  Individual therapy _____ /_____
- Other therapy
  Exercise _____ /_____
  Naturopathic/homeopathic _____ _____ /_____
- If other, specify _____

6.3 Has the child presented to an emergency department at any time during this illness? Yes ___ No ___

6.4 Did the child require hospitalization for this illness? Yes ___ No ___

6.4.1 If yes, indicate the type of ward in which the child was admitted:

General paediatric ward ___ Child and adolescent psychiatry ward ___

General psychiatry ward ___

6.4.2 If the child has already been discharged, what was the total duration of hospital admission?

# of days _____

6.5 If the child has not been discharged, what was the hospital admission date? ____ /_____ /_____
DD MM YYYY

6.6 At the time of your last contact with the family, was the child alive? Yes ___ No ___

6.7 Indicate which of the following health professionals were involved in the patient's care:

Family Physician ___ Paediatrician ___ Psychiatrist ___ Nurse ___ Psychologist ___

Social worker ___ Other, specify: _____

___ **I agree to be contacted by the research team for further information.**

___ **I do not wish to be contacted by the research team for further information.**

SECTION 7 – REPORTING PHYSICIAN

First name_____ Surname_____

Address_____

City_____ Province_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this form.

(EOMD 2012-01)