Rh sensitization (RH)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM
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REPORTING INFORMATION
(To be completed by CPSP staff)

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 Rh SENSITIZATION

Report any infant 60 days of age or less with Rh(D) sensitization fulfilling ALL of the following criteria:

- Mother is Rh negative (D-negative)
- Mother has positive antibody screen due to anti-D. This must be a maternal allo-anti-D, not passive anti-D from Rh(D) immunoglobulin (RhoGAM)
- Cord or infant blood group is Rh positive (D-positive)

SECTION 1 – DEMOGRAPHIC INFORMATION

A. Infant

1.1 Date of birth: ____ /____ /_______ (DD MM YYYY) Time of birth: __ __:__ __ hours

1.2 Sex: Male___ Female___

B. Infant's mother

1.3 Place of residence (province/territory): ____________________________

1.4 Immigrated to Canada? Yes___ No___ Unknown___

If yes, country of origin: ___________________________

Date of arrival : ____ /____ /_______ (DD MM YYYY) Age at arrival: _____________

1.5 Age at delivery (years): ___________

1.6 Ethnicity **(check all that apply):**

___ Arab	___ Black	___ Chinese	___ Filipino
___ Japanese	___ Korean	___ Latin American	___ White
___ First Nations	___ Inuit	___ Métis	___ Unknown
___ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian Laotian)	___ South Asian (e.g., Bangladeshi, Punjabi, Sri Lankan)	___ West Asian (e.g., Afghan, Assyrian, Iranian)	___ Other, specify: _________________________

1.7 Gravida: ______ Para: ______

Abortions – Spontaneous? Yes___; number(s) _____ No___ Unknown___

Therapeutic? Yes___; number(s) _____ No___ Unknown___

1.8 Maternal HBsAg status: Positive___ Negative___ Unknown___

1.9 Maternal blood antibodies: Negative___ Positive___, specify:____________________________ Unknown___

1.10 Received Rh prophylaxis for any previous pregnancies (including miscarriages and for procedures)?

Yes___ No___ Unknown___

1.11 Amniocentesis during infant's gestation? Yes___ No___ Unknown___

1.12 Chorionic villus sampling during infant's gestation? Yes___ No___ Unknown___

1.13 Other prior amniocentesis? Yes___ No___ Unknown___

1.14 Other prior chorionic villus sampling? Yes___ No___ Unknown___

1.15 Transfusions during lifetime, before infant's birth? Yes___ No___ Unknown___

If yes, where? _______________________________

SECTION 2 – FAMILY HISTORY

		Yes	No	Unknown
2.1	Consanguinity?	___	___	___
	If yes, specify: ____________________			
2.2	Infant death(s) during first month of life?	___	___	___
	If yes, specify reason: ____________________			
2.3	Previous sibling with neonatal jaundice?	___	___	___
	If yes, specify reason: ____________________			
	2.3.1 Phototherapy?	___	___	___
	2.3.2 Exchange transfusion?	___	___	___
2.4	Family history or previous sibling diagnosed with G6PD deficiency?	___	___	___
	If yes, specify: ____________________			
	G6PD quantitative levels: Average___ Low___ Very low___ Unknown___			
2.5	Other neonatal hemolytic disease?	___	___	___
	If yes, specify sibling/family member: ____________________			

SECTION 3 – MEDICAL HISTORY

3.1 Gestational age at birth of infant: _____ weeks completed

3.2 Induced delivery related to Rh disease? Yes___ No___

3.3 Type of delivery: Vaginal___ Instrumental___: Forceps___ Vacuum___ Caesarean section___

3.4 If delivery by Caesarean section, was it Rh disease-related? Yes___ No___ Unknown___

3.5 APGAR score at: 1 minute _____ 5 minutes _____ 10 minutes _____

3.6 Birth weight: _____ grams Height: _____ cm Head circumference: _____ cm

3.7 Evidence of fetal hydrops? Yes___ No___

3.8 Evidence of newborn congestive heart failure? Yes___ No___

3.9 Feeding: Breast___ Bottle___ NPO___

3.10 Age at presentation – if <24 hours: _____ hours; otherwise: _____ days

3.11 Month first seen: __________________

3.12 If readmitted, date of readmission: ____ /____ /_______ (DD MM YYYY) Weight on readmission: _____ grams

3.13 Neurological signs:

	Yes	No	Unknown		Yes	No	Unknown
Poor sucking				Arching of neck (retrocollis)			
Arching of trunk (opisthotonus)				Increased muscle tone			
Decreased muscle tone				Seizures			
Level of consciousness – Specify:							

3.14 Drug exposure:

Infant: Yes___ No___ Unknown___

If yes, specify: ______________________________

Mother: Yes___ No___ Unknown___

If yes, specify: ______________________________

3.15 Infection in the neonatal period? Yes___ No___ Unknown___

If yes, specify: ______________________________

3.16 Do you routinely perform serum bilirubin measurements with the newborn screening test? Yes___ No___

3.17 Were parents or caregivers given the predictive nomogram after plotting the result of serum bilirubin testing prior to discharge? Yes___ No___

SECTION 4 – LABORATORY DATA

4.1 Maternal blood group: ABO____ Rh____; specify if reported as: weak D____ or partial D____

4.2 Infant blood group: ABO____ Rh____ Coombs: Direct (DAT)____ Indirect (IAT)____

4.3 Date of presentation: ____ /____ /_______
DD MM YYYY

4.3.1 Hgb: _____ HCT: _____ WBC: _____ Platelets: ______
Blood smear: ____

4.3.2 Serum sodium: _____ BUN: _____ Creatinine: _____

4.3.3 Total bilirubin: _____ µmol/L; Conjugated bilirubin: ______ µmol/L; Unconjugated bilirubin: _____ µmol/L

4.4 Peak bilirubin: _____ µmol/L on ____ /____ /_______ Age – if <24 hours: _____ hours; otherwise: _____ days
DD MM YYYY

4.5 G6PD results: Positive___ Negative___ Unknown___
If positive, specify quantitative level: Average___ Low___ Very Low___

4.6 Osmotic fragility? Yes___ No___ Unknown___
If yes: normal___ abnormal___

SECTION 5 – TREATMENT AND OUTCOME

		Yes	No	Unknown
5.1	Duration of phototherapy: ________ hrs			
5.2	Exchange transfusion?	___	___	___
	If yes, when? ___in utero: ____ /____ /_______ (DD MM YYYY) or ___post delivery ____ /____ /_______ (DD MM YYYY)			
5.3	Received IVIG?	___	___	___
	If yes, how many doses? ______			
5.4	Other transfusions?	___	___	___
	If yes, specify: ___________________________			
5.5	Seizures?	___	___	___

5.6 Neurological status at discharge: Normal___ Unknown___
Hearing loss___ Vision loss___ Motor impairment___ Seizures___

5.7 Outcome: Discharged home___ Still in hospital___
Died___ Age at death: ______ months
Cause of death: ____
Autopsy report: Yes___ No___ Pending___

___I agree to be contacted by the CPSP staff for further information.

___I do not wish to be contacted by the CPSP staff for further information.

SECTION 6 – REPORTING PHYSICIAN

First name______________________________ Surname____

Address____

City______________________________ Province/Territory__________________________ Postal code________________

Telephone number___________________________________ Fax number____

E-mail____ Date completed______________________________________

Thank you for completing this form.